

Health Care Financing Program Statistics

The Medicare and Medicaid Data Book,
1983

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Health Care Financing Program Statistics

The Health Care Financing Administration (HCFA) was established to combine health financing and quality assurance programs within a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 51 million of the Nation's aged, disabled, and poor. The agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that agency policies and actions promote efficiency and quality within the total health care delivery system.

The Office of Research and Demonstrations (ORD) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. In addition, ORD examines the impact of HCFA programs on health care status, utilization, and expenditures, as well as their effect on beneficiary access to services, health care providers, and the health care industry.

The Bureau of Data Management and Strategy operates HCFA's statistical data systems that contain the Medicare and Medicaid program information necessary for managing the agency, directs the actuarial program for HCFA, and serves as the focal point within the agency for information systems policy, planning, and data standards development. In addition, BDMS monitors national health care expenditures and prices and provides analyses on the cost of current HCFA programs as well as the impact of possible legislative or administrative changes in the programs.

The Medicare and Medicaid Data Book, 1983 is the second edition of an annual report that provides an overview of the Medicare and Medicaid programs. This report presents basic data and analyses of the programs for use by policymakers, program managers, health planners, researchers, and other interested individuals. More detailed information on various aspects of the Medicare and Medicaid programs is presented in other reports in the Health Care Financing Program Statistics series.

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The Medicare and Medicaid Data Book, 1983

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Introduction

This volume is the second in a series of descriptive reports and statistics on the Medicare and Medicaid programs.¹ The volume contains data as of 1980 and is intended to serve as a resource for public officials, researchers, policy analysts, and consumers who have an interest in these health programs.

The report is arranged in four chapters. Chapter I provides brief overviews of Medicare and Medicaid and presents information on the relationship between these two programs, including interrelations found in the National Medical Care Utilization and Expenditure Survey (NMCUES), Federal administration of the programs, comparative program expenditures, and the relationship of Medicare and Medicaid expenditures to total personal health care spending.

Chapter II reports trends in the evolution of the Medicare and Medicaid programs. Trends are described for the number of Medicare enrollees and Medicaid recipients; Medicare and Medicaid expenditures; and the use of and expenditures for hospital inpatient and physicians' services in both programs. Trend data for other services in each program are also presented, including Medicaid long-term care utilization and expenditures.

Chapter III describes the major characteristics of the Medicare program, supported by program statistics. Medicare eligibility, benefits, financing, and administration are outlined, for both the hospital insurance (HI) and the supplementary medical insurance (SMI) programs. Data are presented on enrollment and expenditures for both the aged and disabled. Detailed information is provided on Medicare financing and administration, the use of Medicare benefits, and the distribution of reimbursements for various services by different categories of enrollees. The chapter concludes with a description of Medicare's arrangements with Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's), and a discussion of the Medicare statistical system.

Detailed data on the Medicaid program are reported in Chapter IV. Descriptions of Federal rules and State options are followed by information on States' provisions for eligibility and benefits. Statistical information is then presented on service use and expenditures for each State and jurisdiction. Where Federal and State Medicaid data were found to differ during the development of this publication, State data were incorporated into this publication. Hence, the data in this publication may differ slightly from those in other Health Care Financing Administration (HCFA) publications. The chapter also describes Medicaid financing and administration, including matching rates for Federal Financial Participation, recipients and expenditures under State "buy-ins" to Medicare, number of certified providers, adoption of management information systems, fraud and abuse, quality control error rates, and the Medicaid data system. Chapter IV concludes with a brief overview of major changes in Medicaid law brought about by the Omnibus Reconciliation Act of 1981.

Appendices are included in the back of the book to facilitate readers' understanding of the material and to identify additional sources of information. Names and addresses are listed for Medicare intermediaries and carriers. Telephone numbers are supplied for Medicaid State agencies and medical assistance programs, and the offices in HCFA responsible for various facets of the Medicare and Medicaid programs. A glossary and list of abbreviations used in this report are included as well.

I. Introduction to Medicare and Medicaid

This chapter outlines the major characteristics of the Medicare and Medicaid programs. Information is also presented on the relationship between the two programs, including descriptions of the relationship between Medicare and Medicaid for persons jointly eligible under both programs ("dual eligibles") and interrelations as found in the National Medical Care Utilization and Expenditure Survey; how the Federal government is organized to administer both programs; how much each program spends (in total and per enrollee or per recipient) in each State; and the distribution of health care expenditures for each program for different age groups.

A. Overview of the Medicare Program

The Medicare program covers hospital, physicians' and other medical services for most persons 65 years of age and over, disabled persons entitled to social security cash benefits for 24 months, and most persons with end-stage renal disease. Total Medicare expenditures were more than \$35.7 billion in calendar year 1980.

Medicare has two complementary but distinct parts: Hospital insurance (HI), known as Part A, and supplementary medical insurance (SMI), known as Part B. The HI program covers 90 days of inpatient hospital care in a benefit period (spell of illness)—which begins with the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 continuous days. There is no limit to the number of benefit periods an individual may use. The program also provides a non-renewable (life-time) reserve of 60 days if a beneficiary exhausts the 90 days available in a benefit period. In addition to inpatient hospital care, the HI program covers up to 100 post-hospital days in an SNF if it has been certified the beneficiary requires such care. The HI program also covers home health agency (HHA) visits. Effective July 1981, HHA visits do not require prior hospitalization and the limit of 100 visits was removed by the Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499).

About 95 percent of the Nation's aged is enrolled in the HI program. On July 1, 1966, when Medicare became operational, there were 19.1 million aged persons enrolled. By July 1, 1981, the number of aged and disabled enrollees had increased to 29.0 million. This total included 3.0 million disabled enrollees covered by Medicare on July 1, 1973.

Nearly everyone covered by HI voluntarily enrolls for SMI. Unlike HI, SMI requires a monthly premium payment—\$12.20 per month as of July 1982. Under "buy-in" agreements, most State Medicaid programs pay these premiums for persons who qualify for both Medicaid

¹The first report in this series was *The Medicare and Medicaid Data Book, 1981*, Office of Research and Demonstrations, Health Care Financing Administration.

and Medicare benefits. The SMI program provides payments for physicians as well as related services and supplies ordered by physicians. SMI also covers outpatient hospital services, rural health clinic visits, and home health visits.

Several health care services that the aged generally use, such as drugs, dental care, routine eye examinations, and preventive services are not covered by Medicare. Drugs and certain dental procedures are covered only if provided during an authorized hospital inpatient stay. Also, neither ICF nor long-term SNF care is provided.

Both the HI and SMI programs require beneficiary cost sharing. Under HI, the patient is required to pay an inpatient hospital deductible in each benefit period. This deductible (\$260 in 1982) approximates the cost of 1 day of hospital care. Coinsurance, based on the inpatient hospital deductible, is required for the 61st-90th day of inpatient hospital care (equal to 1/4 of the hospital deductible), for the 21st-100th day of skilled nursing facility care (1/8 of the deductible), and for the 60 lifetime reserve days for inpatient hospital care (1/2 of the deductible). The patient is also liable for the cost (or replacement) of the first 3 pints of blood in a benefit period.

Under SMI, in addition to paying a monthly premium, the beneficiary must pay a \$60 deductible each year.² On each claim for payment, physicians can accept or reject assignment. Acceptance of assignment means the physician agrees to accept as full payment the amount Medicare allows for the service. The program reimburses 80 percent of allowed charges directly to the physician. Beneficiaries are liable for the remaining 20 percent (coinsurance) of allowed charges. On unassigned claims, the beneficiary is also responsible for the difference between the physician's charge and the allowed charge. The Medicaid program assumes cost sharing for Medicaid beneficiaries covered under buy-in agreements. (As of 1980, 46 States had a buy-in program).

Medicare benefits and administrative expenses are paid from two separate trust funds. The HI trust fund is financed primarily through a tax on current earnings from employment covered by the Social Security Act. The SMI trust fund is financed through premiums paid by or on behalf of persons enrolled in the program, and by the Federal government from general revenues.

B. Overview of the Medicaid Program

Medicaid is a federally supported and State administered assistance program that provides medical care for certain low income individuals and families. Medicaid accounted for over \$23 billion in Federal and State expenditures for medical services in fiscal year 1980.

The program is designed to provide medical assistance to those groups or categories of people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act; that is, Title IV-A, the program of Aid to Families with Dependent Children (AFDC); or Title XVI, the Supplemental Security Income (SSI) program for the

aged, blind, and disabled. In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid.³ In addition, States may provide Medicaid to the "medically needy," that is, to people who (1) fit into one of the categories of people covered by the cash assistance programs (aged, blind, or disabled individuals or members of families with dependent children when one parent is dead, absent, incapacitated, or at State discretion—unemployed), and who (2) are not recipients of cash assistance but whose income falls below certain levels.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing facility services for individuals 21 years of age and over, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis, and treatment services for individuals under 21 years of age. In addition, States may elect to provide a number of other services, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21 years of age, physical therapy, and dental care.

Medicaid is a vendor payment program, that is, payments are made directly to providers of service for care rendered to eligible individuals. Providers who choose to participate in the program must accept the Medicaid reimbursement level as full payment. In long-term care institutions, individuals must turn over income in excess of their personal needs and maintenance needs of their spouses to help pay for their care. States may not require the categorically eligible to share costs for mandatory services.⁴ But they may require other Medicaid recipients to share in the cost of certain services. As noted previously, most State Medicaid programs have buy-in agreements with Medicare. Under these agreements, Medicaid pays the Part B Medicare premiums and cost sharing for persons covered under both programs.

Medicaid is financed jointly with State and Federal funds. Federal contributions vary with States' *per capita* income and currently range from 50 percent to 78 percent of program medical expenditures. Administration, fraud and abuse, and Medicaid Management Information System (MMIS) costs are matched at other rates. States participate in the Medicaid program at their option. All States except Arizona currently have Medicaid programs.⁵ The District of Columbia, Puerto Rico, Guam,

³Chapter IV contains a more detailed discussion of the major differences among States in the criteria used to determine program eligibility.

⁴The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) now permits States to require cost sharing of certain categorically eligible recipients. The Act also made a number of other changes in the Medicaid program, such as allowing for coverage of home care for certain disabled children and the establishment of a Medicaid program on American Samoa. The data and descriptions in this volume cover the programs as they were in FY 1980. Hence, the 1981 and 1982 congressional modifications are noted only anecdotally.

⁵Effective November 9, 1981, Arizona established the Health Care Cost Containment System which provides health care to the poor based on a prepaid, capitated approach. This system currently is being run as a HCFA supported demonstration program.

²The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) raised the deductible to \$75, effective January 1, 1982.

the Northern Marianas, and the Virgin Islands also provide Medicaid coverage. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms.⁹ As a result, the characteristics of Medicaid programs vary considerably from State to State.

C. Comparative View of Medicare and Medicaid

1. Comparison of Medicare and Medicaid Data

There are marked differences in the statistical systems supporting the Medicare and Medicaid programs. These differences obviously limit the comparisons that can be made across the two programs. This section compares some of the differences between the two systems as they relate to the data presented in this report.

The Medicare statistical system collects data on enrollees, that is, persons eligible for Medicare. In addition, data are shown for enrollees who received services for which reimbursements were made (referred to as "persons served"). In contrast, Federal Medicaid statistics consist of aggregate counts of the number of recipients (as opposed to enrollees) and dollars expended on covered services. Most of the Medicare statistics in this report are from Medicare claims centrally processed in HCFA's Baltimore offices. The Baltimore Center tabulates data on the services of each person reimbursed. Medicaid statistics also are centrally maintained in the Baltimore office, but only after they have been aggregated into recipient and expenditure counts by the States. Thus, unlike most Medicare data, HCFA data on the Medicaid program cannot be disaggregated. The Medicare claims data are generally reported for the calendar year in which medical services were rendered, rather than the date when Medicare payment was made. Conversely, the Medicaid recipient and expenditure counts included in the tables are reported for the fiscal year in which services were paid. For more information on the Medicare and Medicaid data systems, see the last sections of Chapters III and IV.

2. Interrelated Coverage

Through buy-in agreements, approximately 12 percent of aged and disabled Medicare enrollees are also covered by State Medicaid programs. States can obtain SMI coverage for the dually entitled under buy-in agreements with Medicare. States that buy coverage pay the SMI premium and are responsible for Medicare cost sharing. When persons are eligible under both programs, Medicare makes the primary payment for Medicare services, and Medicaid pays the deductible and coinsurance. States receive Federal matching payments for these expenditures. While States may buy into Medicare for any of their Medicaid-Medicare eligibles, they receive Federal matching payments on premium payments only for persons receiving cash assistance (that is, the categorically needy). States must pay the full cost of premium payments for other Medicaid eligibles.

If a State does not buy SMI coverage for Medicare-Medicaid eligibles, it cannot receive Federal matching payments for services that would have been covered under Medicare. Among States and jurisdictions with Medicaid programs (all States except Arizona), 46 States and jurisdictions had buy-in arrangements as of 1980, and 4 States and 1 jurisdiction did not (Alaska, Louisiana, Oregon, Wyoming, and Puerto Rico).

State Medicaid programs also provide many services for the aged and disabled not provided by Medicare, including skilled nursing facility care beyond the 100-day post-hospital benefit provided by Medicare, long-term care in intermediate care facilities (ICF's), prescription drugs, eyeglasses, and hearing aids. In this respect, Medicaid is more comprehensive than Medicare in the range of benefits a State may provide. It also has a more pronounced long-term care orientation because there are no Federal limits on nursing home length-of-stay and because the law allows States to cover ICF's and Medicare does not.

3. The 1980 National Medical Care Utilization and Expenditure Survey

The 1980 National Medical Care Utilization and Expenditure Survey (NMCUES) collected national health data from a sample of the civilian noninstitutionalized population. Among the data items collected were health insurance coverage, expenditures, source of payment for health services, and selected sociodemographic characteristics of each of the persons in the survey. In addition to the national sample, there were two other data components: a four-State sample of Medicaid enrollees from California, Michigan, New York, and Texas, and the verification from administrative records of Medicare and Medicaid eligibility and health expenditures. The data presented here are limited to aged Medicare enrollees and provide figures on persons with both Medicare and Medicaid coverage as described in the previous section.

Table 1.1 shows the distribution of several demographic and other health-related characteristics for five major insurance coverage categories. The category "Medicare only" includes people who reported being covered by Medicare and no other insurance plan, and represents 21 percent of the Medicare elderly. The category "Medicare and Medicaid" consists of those persons reporting coverage under both the Medicare and Medicaid programs (and no other coverage), and represents 10 percent of the total. The largest category (65 percent), "Medicare and private only," is made up of persons reporting coverage by Medicare and one or more private health insurance plans. These private plans range from comprehensive Medicare supplements to fixed-dollar indemnity plans. (Respondents were instructed not to include dread disease, direct cash, and accidental injury policies as private health insurance.) Another 2.5 percent of the aged had Medicare, Medicaid, and private insurance. The remaining 1 percent of the Medicare elderly had Medicare and some other combination of coverage (for example, Medicaid and one or more private plans, CHAMPUS). Thus, nearly four out of five of the aged covered by Medicare are estimated to have insurance coverage in addition to Medicare.

⁹Some States may also include persons not eligible for Federal matching ("State-only" or "medically indigent" persons) in their medical assistance programs, and receive no Federal contributions for the costs of their care.

TABLE 1.1

Health Insurance Coverage of Noninstitutionalized Medicare Enrollees
64 Years of Age and Over,¹ by Selected Characteristics, United States, 1980

Selected Characteristics	Health Insurance Coverage					
	Aged Medicare Enrollees	Percent Medicare Only	Percent Medicare and Medicaid Only	Percent Medicare, Medicaid and Private	Percent Medicare and Private Only	Percent Medicare and Other Combinations
Total	23,263,850	21.2	10.2	2.5	64.9	1.3
Education						
Under 8 Years	5,512,405	31.4	22.5	2.9	42.4	.8*
8 Years	4,468,419	23.8	8.5	3.5*	63.8	.5*
9-11 Years	4,032,214	22.3	11.1	3.5*	61.8	1.3*
12 Years	4,805,885	13.9	4.5*	1.3*	78.3	2.1*
13 or More Years	4,444,926	12.9	2.1*	1.2*	82.2	1.7*
Perceived Health Status						
Excellent	6,016,924	19.4	4.3	1.3*	73.1	1.9*
Good	8,572,441	21.1	9.1	2.3	66.1	1.4*
Fair	5,894,957	23.3	11.1	2.9*	62.3	.4*
Poor	2,715,066	20.4	25.0	4.5*	48.7	1.4*
Unknown	64,461*	46.2*	0.0	0.0	53.8*	0.0
Race						
White	21,056,368	20.1	8.5	2.4	67.9	1.2*
Black	1,913,610	33.2	26.2	3.7*	35.0	1.9*
Other Races	293,871	25.6*	28.4*	2.3*	43.7*	0.0
Region						
Northeast	4,698,414	20.7	7.1	2.7	69.0	.6*
North Central	5,671,328	15.3	6.7	2.1*	74.9	1.0*
South	7,727,353	24.2	12.4	2.8	59.8	.9*
West	5,166,755	23.8	13.7	2.1*	57.8	2.7*
Age						
64-74	15,449,797	19.5	8.7	2.1	68.5	1.3*
75 and Over	7,814,052	24.6	13.1	3.3	57.8	1.2*
Annual Family Income						
Under \$5,000	5,138,593	28.1	22.6	4.6	44.0	.8*
\$5,000-\$9,999	7,342,263	22.2	8.3	2.2	66.2	1.1*
\$10,000-\$19,999	6,765,723	16.1	4.6	1.7*	76.1	1.6*
\$20,000 or More	4,017,271	19.1	7.3	1.6*	70.4	1.6*

¹ Age 64 and over on January 1, 1980. Estimates are person-years of Medicare coverage.

*Relative standard error for this cell exceeds 25 percent.

SOURCE National Medical Care Utilization and Expenditure Survey.

The type of insurance coverage varied by demographic and other characteristics shown in Table 1.1. As years of education increased, the percentage covered by only Medicare decreased (from 31 to 13 percent) and the percentage covered by Medicare and Medicaid decreased (from 23 to 2 percent). Conversely, the percentage covered by Medicare and private insurance increased with education (from 42 to 82 percent).

About 20 percent of aged Medicare enrollees (regardless of their health status) reported Medicare as their only source of health coverage. The proportion of persons with Medicare and Medicaid increased from 4 percent for those reporting excellent health to 25 percent for those reporting poor health; a reverse pattern was noted among those with Medicare, Medicaid, and private insurance. Seventy-three percent of those in excellent health had Medicare and private insurance compared to 49 percent of those in poor health.

Black persons were more likely than white persons to be covered by Medicare only (33 versus 20 percent) and by Medicare and Medicaid in combination (26 versus 9 percent). By region, higher proportions of enrollees in the South and West had Medicare and Medicaid in combination. As age increased, those with only Medicare increased, from 20 percent of persons 64–74 years of age to 25 percent of persons 75 years of age and over. Because income is the main criteria for Medicaid eligibility, 23 percent of those with family income below \$5,000 a year had Medicare and Medicaid coverage—far more than those with higher incomes.

Table 1.2 shows expenditures for health care and the sources of those expenditures. Also shown are the percentage of the total paid and the mean expenditure per person by several payment sources and by type of insurance coverage. In 1980, of the \$41.7 billion in expenditures for noninstitutionalized aged enrollees, Medicare spent \$23.4 billion, patients and their families (out-of-pocket) spent \$7.6 billion, and private insurance paid \$6.1 billion. As a group, the Medicare elderly averaged \$1,791 per person in health care expenditures. Of this total, Medicare paid an average of \$1,005 (56 percent), and an average of \$328 (18 percent) per person was paid out of pocket. Among the insurance coverage groups, average total expenditures per person for the “Medicare and Medicaid only” group were 75 percent higher than for the Medicare elderly taken as a group (\$3,133 versus \$1,791), and were nearly three times as high as for the Medicare only group (\$3,133 versus \$1,087). Mean out-of-pocket expenditures were lowest among those covered by Medicare and Medicaid only—less than half of the average for the total group (\$133 versus \$328).

4. Medicare Enrollees and Persons Served, Medicaid Recipients, and Program Expenditures

Table 1.3 relates Medicare and Medicaid population data to program expenditures. In calendar year 1980, 18.0 million (63 percent) of the 28.5 million aged and disabled persons enrolled in Medicare received reimbursable health services; 21.6 million individuals received health services paid by Medicaid in fiscal year 1980.⁷

Twenty-six percent of all persons served under the Medicare program resided in California, New York, or Florida. For Medicaid, the three States with the largest number of recipients in FY 1980 were California, New York, and Pennsylvania, which together accounted for 32 percent of all Medicaid recipients.

In CY 1980, \$33.6 billion were spent on behalf of Medicare enrollees and \$23.3 billion were spent on behalf of Medicaid recipients. Medicare reimbursements for California residents (\$4.0 billion) were higher than in any other State. Reimbursements for residents of New York (\$3.2 billion), Florida (\$2.2 billion), and Pennsylvania (\$2.1 billion) were next in amounts reimbursed. Together, these four States accounted for 34 percent of total Medicare reimbursements. Payments for Medicaid recipients were highest in New York (\$4.5 billion), California (\$2.7 billion), Illinois (\$1.2 billion), Pennsylvania (\$1.1 billion), and Michigan (\$1.1 billion). These five States accounted for 45.5 percent of total Medicaid expenditures.

In CY 1980, the average Medicare reimbursement per person served in the U.S. was \$1,868. The average payment per Medicaid recipient was \$1,078 in FY 1980. Medicare enrollees in the District of Columbia had the highest reimbursement per person served (\$2,727) with total reimbursements of \$151 million. Next in dollar amounts were Illinois, (\$2,418) with total reimbursements of \$1,894 million, and Nevada (\$2,415) with total reimbursements of \$110 million. Payments per Medicaid recipient were highest in New York (\$1,985) with total payments of \$4,542.0 million, Indiana (\$1,726) with total payments of \$354.2 million, and New Hampshire (\$1,603) with total payments of \$71.9 million.

Figures 1.1, 1.2, and 1.3 illustrate several important differences between Medicare and Medicaid. As Figure 1.1 shows, Medicare is oriented toward acute care services, consistent with its statute. Inpatient hospital care accounts for nearly two-thirds of total Medicare reimbursements (HI and SMI combined). Only 1 percent of Medicare reimbursements go to SNF's, with coverage limited to short-term, post-hospital recuperative or rehabilitative care. In contrast, although inpatient hospital services absorb only 27.8 percent of total Medicaid payments, payments for long-term care in nursing homes, both ICF's and SNF's, make up 42.5 percent of total Medicaid payments.

Medicare and Medicaid also differ in the relative size and distribution of reimbursements among their enrollee and eligibility groups. As Figure 1.2 shows, Medicare serves predominantly the aged who comprise 90 percent of all enrollees and receive 87 percent of all reimbursements.

Figure 1.3 illustrates the distribution of recipients and payments under the Medicaid program by eligibility. The aged and disabled make up less than 29 percent of all recipients, but are responsible for over 67 percent of all payments. In contrast, children and adults eligible through AFDC criteria make up almost two-thirds of all recipients, but account for less than 29 percent of total payments.

⁷No reliable national estimates of the total number of persons enrolled in Medicaid at any one time or over a period of time were available before April 1980.

TABLE 1.2

Expenditures for Health Care of Noninstitutionalized Medicare Enrollees 64 years of Age and Over,¹
by Source of Payment and Health Insurance Coverage, United States, 1980

Source of Payment	Health Insurance Coverage				
	Total	Medicare Only	Medicare and Medicaid Only	Medicare and Private Health Insurance Only	Medicare and Other Plans
Total Expenditures (in thousands)					
Out-of-Pocket	\$ 7,637,654	\$1,569,841	\$ 315,670	\$ 5,698,904	\$ 53,239*
Medicare	23,375,509	3,597,149	4,270,217*	15,482,361 ₂	25,782*
Medicaid	3,067,797	₂	2,727,522 ₂		0
Private Plans	6,059,122	₂		5,960,122	0
Other Sources	1,222,014	73,344*	12,926*	823,210*	312,535*
Unknown Source/ Unpaid Amount	310,128	68,299*	56,663*	184,812*	354*
Total	41,672,226	5,364,437	7,437,995	28,477,883	391,911*
Percentage of Total Expenditures					
Out-of-Pocket	18.3	29.3	4.2	20.0	13.6*
Medicare	56.1	67.1	57.4	54.4	6.6*
Medicaid	7.4	₂	36.7 ₂	₂	0.0
Private Plans	14.5	₂		20.9	0.0
Other Sources	2.9	1.4*	.2*	2.9*	79.8
Unknown Source/ Unpaid Amount	.7	1.3*	.7*	.7*	.1*
Total	100.0	100.0	100.0	100.0	100.0
Mean Expenditure per Person					
Out-of-Pocket	\$ 328	\$ 318	\$ 133	\$ 364	\$ 184*
Medicare	1,005	729	1,799*	988	89*
Medicaid	131	₂	1,149 ₂	₂	0.0
Private Plans	260	₂		380	0.0
Other Sources	53	15*	5*	53*	1,078*
Unknown Source/ Unpaid Amount	13	14*	24*	12*	1*
Total	1,791	1,087	3,133	1,818	1,352

¹ Age 64 and over on January 1, 1980. Estimates are person-years of Medicare coverage.

² Figures in these cells have been omitted. They result from the collection of data for health insurance from one source and source of payment from a different source. Logically, if enrollees have Medicare only they could not have Medicaid or private health insurance.

*Relative standard error for this cell exceeds 25 percent.

SOURCE: National Medical Care Utilization and Expenditure Survey.

TABLE 1.3

Medicare Enrollees and Reimbursements, and Medicaid Recipients and Payments, 1980

	Medicare Enrollees ² (thousands)	Medicare Persons Served ³ (thousands)	Medicaid Recipients ⁴ (thousands)	Medicare Reimbursements ³ (millions)	Medicaid Payments (millions)	Medicare Reimbursement Per Person Served ³	Medicaid Payment per Recipient
All Areas ¹	28,478.2	18,031.8	21,604.4	\$33,612.5	\$23,301.1	\$1,864	\$1,078
United States	27,889.9	17,926.9	20,205.0	33,491.4	23,200.0	1,868	1,148
Alabama	491.3	298.2	324.4	502.8	263.5	1,686	812
Alaska	12.6	7.4	17.2	17.9	26.7	2,408	1,554
Arizona ⁵	328.1	215.9	NA	381.6	NA	1,768	NA
Arkansas	348.6	219.1	222.5	324.1	234.7	1,479	1,054
California	2,629.6	1,858.4	3,417.7	4,004.9	2,728.2	2,155	798
Colorado	267.9	176.2	141.3	300.7	181.7	1,707	1,286
Connecticut	393.5	268.3	216.6	473.0	349.7	1,763	1,615
Delaware	66.5	44.3	49.2	81.7	45.3	1,846	920
District of Columbia	78.6	55.4	126.7	151.0	168.5	2,727	1,330
Florida	1,726.4	1,210.2	500.7	2,167.6	392.0	1,791	783
Georgia	587.4	367.7	430.3	581.8	462.4	1,583	1,075
Hawaii	81.4	54.5	106.6	99.3	96.2	1,823	902
Idaho	103.8	64.9	43.9	94.6	52.0	1,456	1,182
Illinois	1,351.3	783.4	1,048.6	1,894.4	1,191.9	2,418	1,137
Indiana	642.3	378.7	205.3	683.1	354.2	1,804	1,726
Iowa	415.9	248.8	178.4	426.2	230.2	1,713	1,290
Kansas	325.9	218.0	149.0	382.7	201.8	1,755	1,355
Kentucky	463.3	247.1	410.2	404.6	295.6	1,637	721
Louisiana	443.1	245.6	365.2	438.1	415.2	1,784	1,137
Maine	158.4	104.8	145.6	166.3	131.3	1,587	902
Maryland	422.4	277.3	312.5	591.7	319.6	2,134	1,023
Massachusetts	779.0	532.0	774.9	1,117.9	1,009.3	2,101	1,302
Michigan	1,034.0	713.7	973.4	1,475.9	1,071.7	2,068	1,101
Minnesota	514.0	328.2	325.4	564.3	590.4	1,720	1,814
Mississippi	325.8	192.9	306.9	301.1	211.0	1,561	688
Missouri	705.9	428.6	321.5	829.9	295.1	1,936	918
Montana	94.2	57.3	45.8	91.8	62.3	1,603	1,361
Nebraska	219.0	123.7	71.3	213.8	108.8	1,728	1,526
Nevada	73.1	45.6	25.2	110.1	44.9	2,415	1,781
New Hampshire	112.5	72.5	44.9	109.6	71.9	1,510	1,603
New Jersey	942.9	641.2	676.3	1,123.6	755.9	1,752	1,118
New Mexico	129.5	79.2	87.9	126.6	70.3	1,598	800
New York	2,364.7	1,659.4	2,288.1	3,181.1	4,542.6	1,917	1,985
North Carolina	679.6	399.9	376.7	621.7	401.1	1,555	1,065
North Dakota	87.3	58.0	31.4	95.6	47.0	1,647	1,489

(continued)

TABLE 1.3 (continued)

Medicare Enrollees and Reimbursements, and Medicaid Recipients and Payments, 1980

	Medicare Enrollees ² (thousands)	Medicare Persons Served ³ (thousands)	Medicaid Recipients ⁴ (thousands)	Medicare Reimbursements ³ (millions)	Medicaid Payments (millions)	Medicare Reimbursement Per Person Served ³	Medicaid Payment per Recipient
Ohio	1,303.1	801.7	808.6	1,513.8	809.4	1,888	1,001
Oklahoma	401.6	240.3	253.6	416.3	265.4	1,732	1,046
Oregon	331.0	209.3	277.1	379.8	178.9	1,815	646
Pennsylvania	1,681.2	1,095.9	1,250.6	2,086.0	1,058.2	1,903	846
Rhode Island	138.4	106.8	127.8	170.9	160.4	1,600	1,255
South Carolina	329.5	191.3	337.3	285.4	259.2	1,492	768
South Dakota	98.4	55.4	34.9	87.7	54.9	1,582	1,575
Tennessee	578.7	337.4	354.4	566.2	379.5	1,678	1,071
Texas	1,457.6	896.3	687.7	1,630.3	980.9	1,819	1,426
Utah	117.8	71.3	57.4	102.7	79.6	1,441	1,387
Vermont	65.1	42.3	53.8	67.4	59.3	1,591	1,102
Virginia	558.4	343.3	320.4	586.4	359.0	1,708	1,120
Washington	469.1	308.9	315.2	484.5	329.0	1,569	1,044
West Virginia	275.8	150.6	129.4	245.1	103.6	1,627	801
Wisconsin	617.4	374.5	424.5	684.4	686.0	1,828	1,616
Wyoming	40.7	23.4	11.1	45.7	14.4	1,957	1,307
State Unknown	26.4	1.7	NA	7.8	NA	4,477	NA
U.S. Territories and Possessions ⁶	359.4	100.0	1,399.4	114.0	101.1	1,139	72
Guam	2.3	.6	—	1.8	—	3,094	—
Puerto Rico	351.4	97.5	1,386.1	109.1	99.5	1,119	72
Virgin Islands	4.9	1.8	13.3	2.9	1.6	1,590	119
Foreign Countries	228.9	4.9	NA	7.2	NA	1,474	NA

¹ For Medicare: area of enrollee. For Medicaid: area of provider of medical services.² As of July 1, 1980.³ Medicare data are for services incurred in calendar year 1980.⁴ Medicaid data are for services paid during fiscal year 1980.⁵ Arizona does not have a Medicaid program.⁶ Includes all other outlying areas.

"—" Data not available.

NA Not applicable.

SOURCES: Medicare statistics are from Medicare Program Statistics Branch, and the Medicaid statistics are from the Medicaid Program Data Branch, Office of Research and Demonstrations, HCFA.

TABLE 1.4
Personal Health Care Expenditures, by Source of Payment and Age, Calendar Year 1978
(dollars in millions)

Age	Total Expenditures	Private	Public			
			Total	Medicare	Medicaid	Other ¹
All Ages	\$167,911	\$102,870	\$65,042	\$24,919	\$18,365	\$21,758
Under 19	19,875	14,180	5,696	30	3,142	2,524
19-64	98,668	70,497	28,172	3,114	8,612	16,446
65 and Over	49,366	18,192	31,175	21,775	6,611	2,789
Percent Distributions						
All Ages	100.0	61.3	38.7	14.8	10.9	13.0
Under 19	100.0	71.3	28.7	.2	15.8	12.7
19-64	100.0	71.4	28.6	3.2	8.7	16.7
65 and Over	100.0	36.9	63.2	44.1	13.4	5.6

¹ Includes health care expenditures by the Veterans Administration, the Department of Defense, workers compensation programs, State and local governments (other than Medicaid), and Federal medical assistance programs (other than Medicare and Medicaid).

SOURCE: Charles R. Fisher, "Differences by Age Groups in Health Care Spending," *Health Care Financing Review* (Spring 1980), pp. 65-90.

5. The Administration of Medicare and Medicaid

Medicare and Medicaid were administered by separate agencies in the Department of Health, Education, and Welfare from 1965 to 1977. In 1977, these agencies were merged into the Health Care Financing Administration (HCFA) within the Department of Health and Human Services. Under the new structure, the operation of Medicare and Medicaid was combined by having each of the newly created bureaus and offices deal with specific aspects of both programs. These changes were designed to reduce duplication of effort and enhance consistency and coordination of Medicare and Medicaid (*Perspectives*, HCFA 79-20021). An intermediate level of Associate Administrators was subsequently added in 1981. As shown in Figure 1.4, four senior officials now report to the Administrator and Deputy Administrator on the following phases of HCFA operations:

- Associate Administrator for Operations
- Associate Administrator for Policy
- Associate Administrator for Management and Support Services
- Associate Administrator for External Affairs

6. Medicare, Medicaid, and Total Expenditures for Personal Health Care

Table 1.4 shows the distribution of national personal health care expenditures in 1978 by various age groups and by sources of payment. Source of payment comprises private sources (direct payment by individuals and by private insurance) and public sources (Medicare, Medicaid and other public programs). In 1978, for the aged, public programs paid 63.2 percent of all personal health care expenditures, 44.1 percent by Medicare, 13.4 percent by Medicaid, and 5.6 percent by other public programs. For 1980, the comparable figure was 64 percent, with 45 percent accounted for by Medicare, 14 percent by Medicaid, and 5 percent by other public programs. (Preliminary Estimates, Division of National Cost Estimates, BDMS).

Medicaid paid a larger proportion of the personal health care costs of the young (15.8 percent—under 19 years) and the aged (13.4 percent—65 and over) than those 19-64 years (8.7 percent). Medicaid is also the most important public program paying nursing homes care. In 1978, it paid 39 percent of total nursing home care for the aged (Fisher, 1980). In contrast, Medicare paid for 75 percent of all hospital care and 56 percent of all physicians' services. In 1978, Medicare and Medicaid accounted for 26 percent of all personal health care expenditures. By 1980, these two programs paid 28 percent of the total personal health care expenditures (Gibson and Waldo, 1982).

FIGURE 1.1
Distribution of Medicare Reimbursements and Medicaid Payments,
by Type of Service, 1980

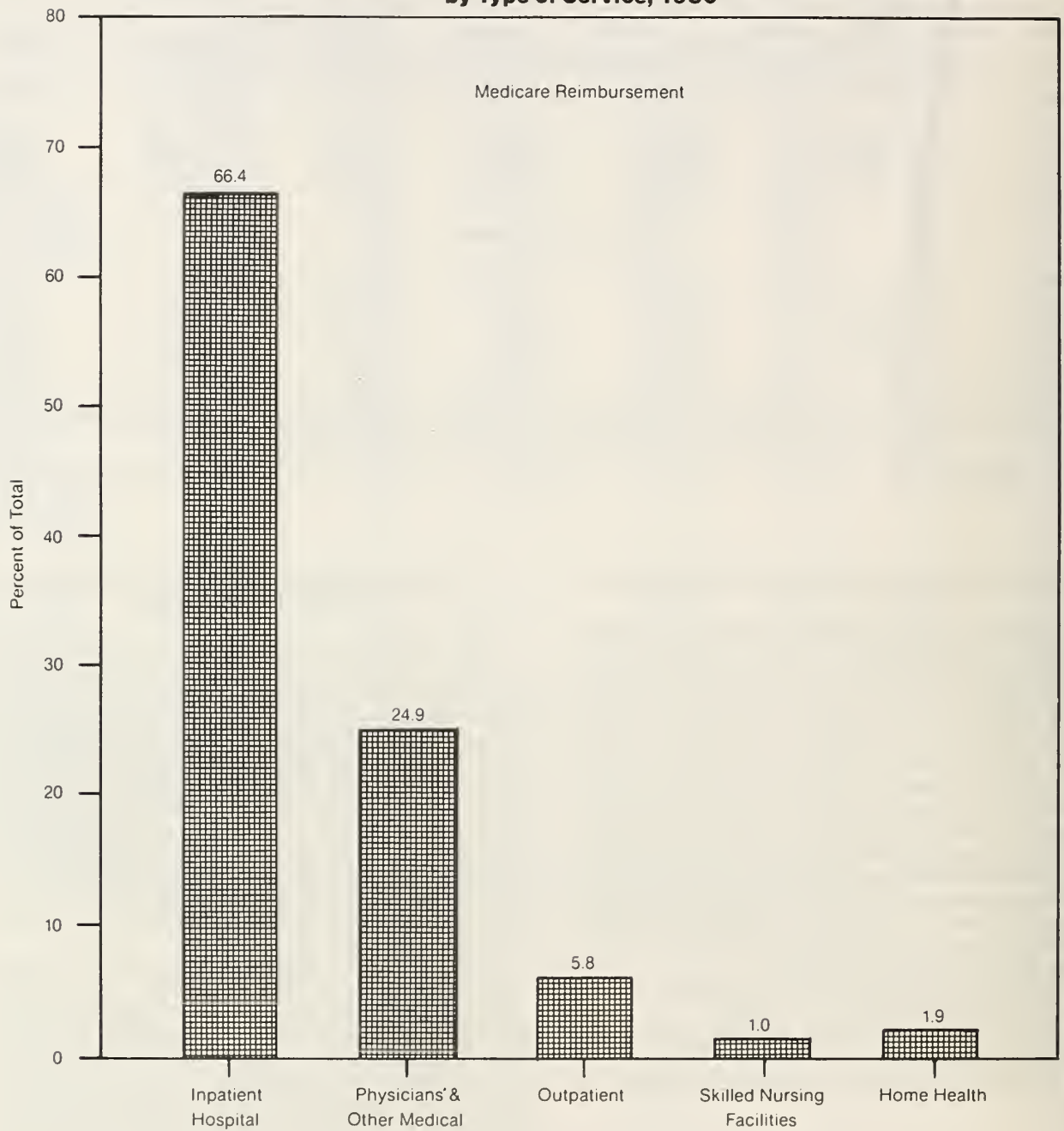


FIGURE 1.1 (Continued)
Distribution of Medicare Reimbursements and Medicaid Payments,
by Type of Service, 1980

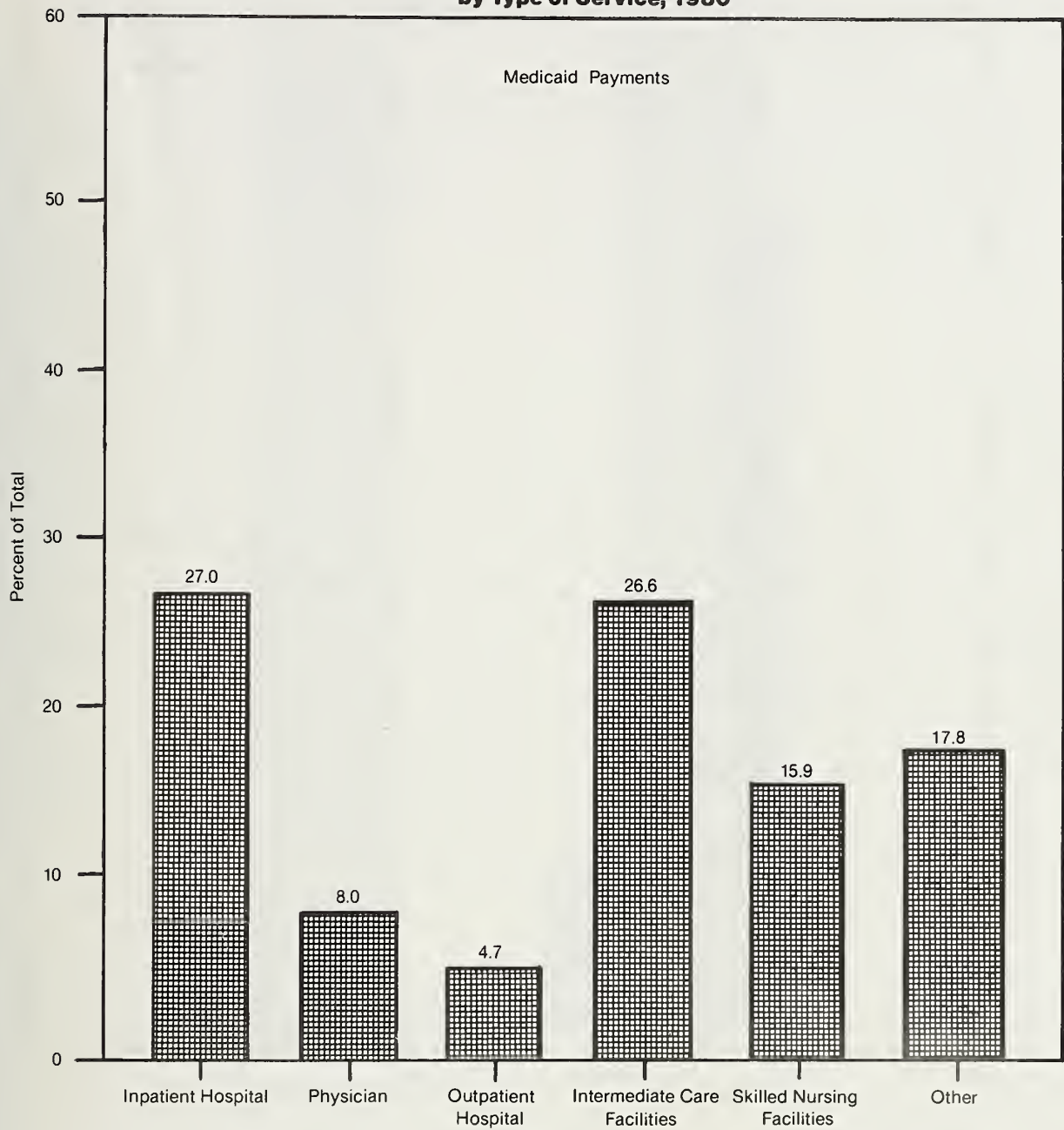


FIGURE 1.2
Distribution of Medicare Enrollments and Reimbursements,
by Type of Enrollee, 1980

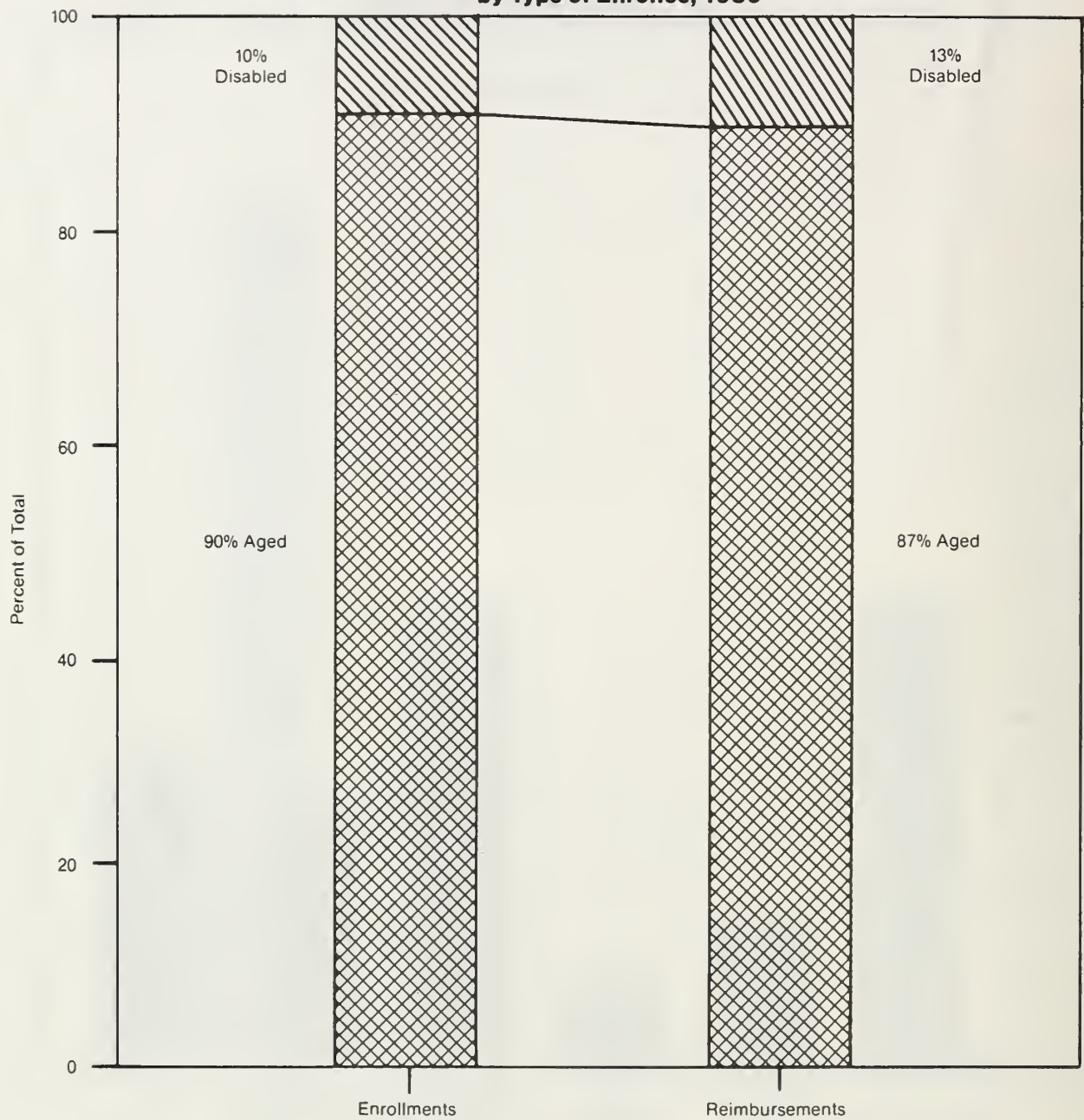


FIGURE 1.3
Distribution of Medicaid Recipients and Payments,
by Basis of Eligibility, Fiscal Year 1980

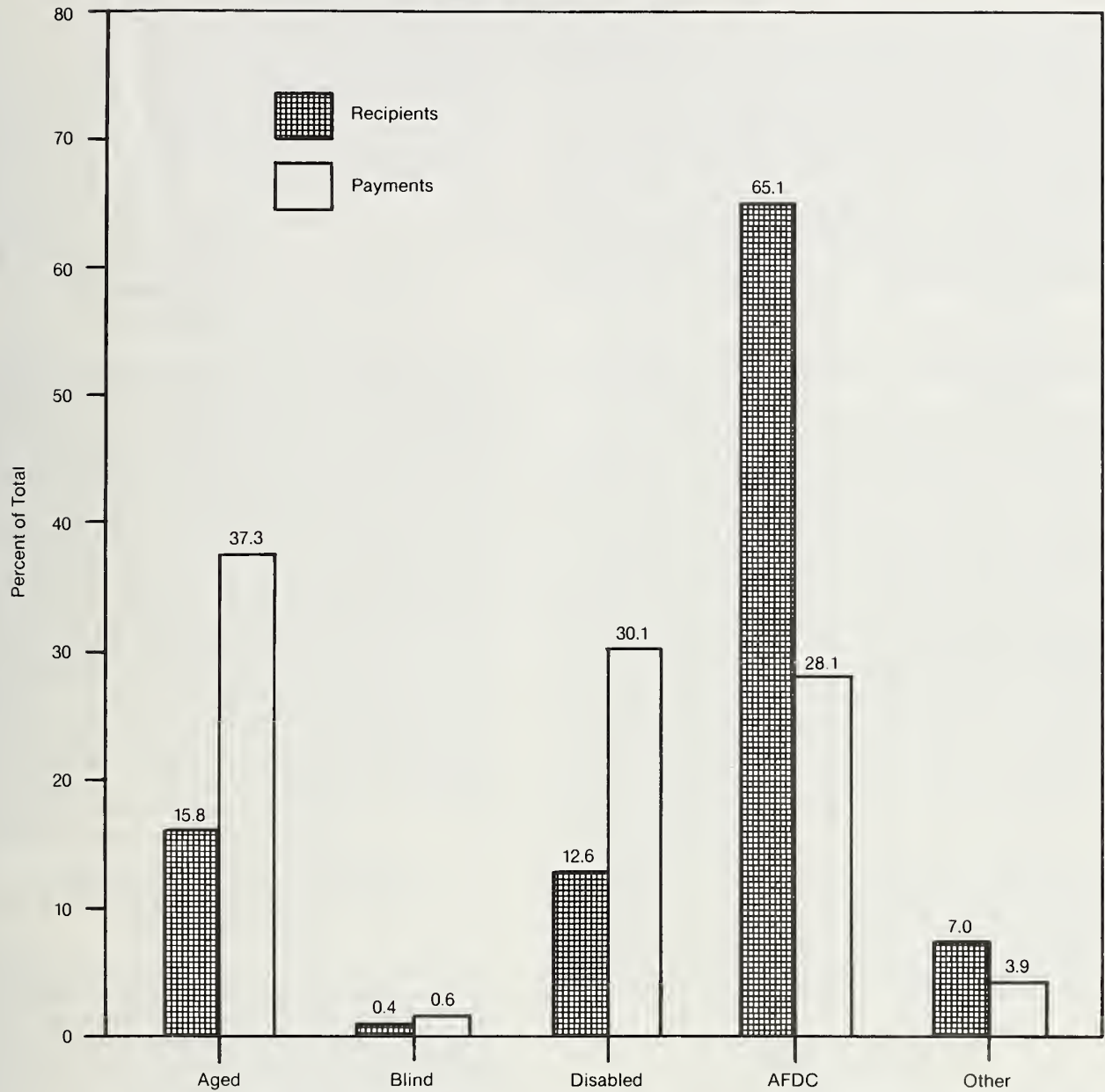
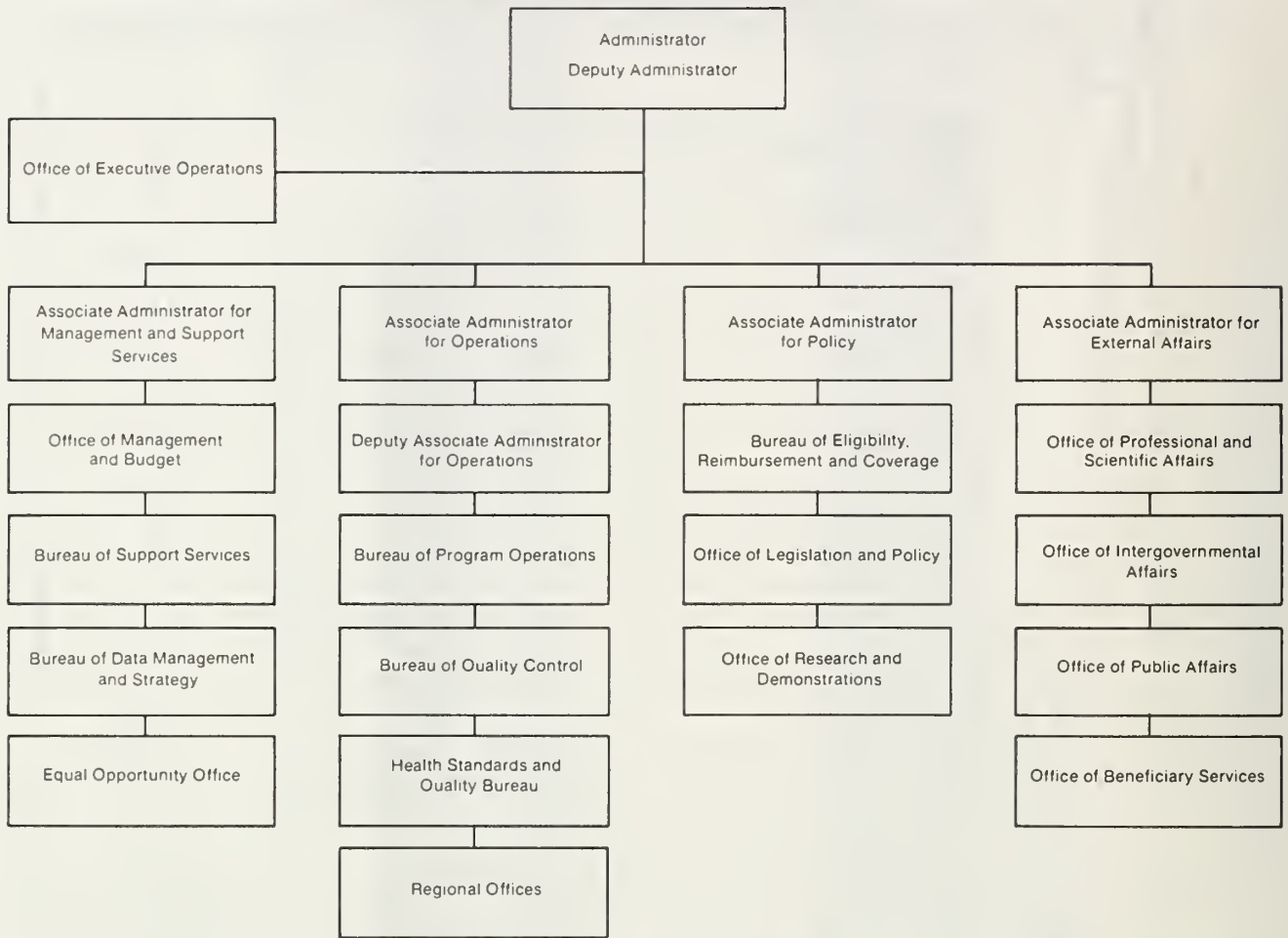


FIGURE 1.4

Health Care Financing Administration Organization Chart, January 1983



II. Medicare and Medicaid Trends

This chapter reports trends in the Medicare and Medicaid programs. Section A describes changes in the number of Medicare enrollees and Medicaid recipients, by basis of eligibility and by population characteristics. Data on Medicare and Medicaid expenditures—in total and by eligibility category—are presented in Section B. Section C compares trends in the use of and expenditures for inpatient hospital and physicians' services for Medicare and Medicaid. Sections D and E present trend data for other services financed by the Medicare and Medicaid programs.

A. Enrollees and Recipients

1. Trends in Medicare Enrollees and Medicaid Recipients

Table 2.1 shows that the number of aged and disabled Medicare enrollees increased 2.9 percent per year from 1966 through 1980. Supplementary medical insurance (SMI) enrollment increased slightly faster than hospital insurance (HI) enrollment. Total enrollment jumped over 10 percent between 1972 and 1973, reflecting the extension of Medicare coverage to the disabled by the 1972 amendments to the Social Security Act. Prior to the 1972 amendments, only persons 65 years of age and over were covered by Medicare.

From 1973 to 1980, the number of Medicaid recipients (persons who actually received services paid by Medicaid) increased at an average rate of 1.4 percent a year.^a This overall upward trend included periods of both growth and decline. The number of Medicaid recipients increased until 1977 and then declined in the 2 succeeding years at an annual rate of 3.1 percent. A slight upturn of .2 percent subsequently occurred between 1979 and 1980. Overall, the number of recipients in 1980 was 10.1 percent greater than in 1973. Figure 2.1 shows graphically the data reported in Table 2.1

2. Number of Aged Medicare Enrollees Having HI and SMI Coverage, by Age, Sex, and Race, July 1, 1966-1980

Table 2.2 presents data on the number of aged HI and SMI enrollees by age, sex, and race for calendar years 1966 through 1980. All demographic groups in the table grew in size, with SMI enrollment increasing faster than HI enrollment in each group. For both HI and SMI, women, persons of races other than white, and those 75 years of age and over had greater enrollment increases than other groups. This gradual aging of Medicare enrollees has long-term consequences for the Medicare program because older enrollees are relatively high users of health care services and raise the reimbursement per enrollee.

^aThe Medicaid data presented in this report were first compiled in the present format in FY 1973. Previous data were based on reporting categories which were different from those now used. To avoid erroneous inferences, the data for earlier years are excluded from this report.

3. Number of Disabled Medicare Enrollees Having HI and SMI Coverage, by Age, Sex, and Race, July 1, 1973-1980

The rate of growth in the number of disabled enrollees (Table 2.3) was much greater than that of aged enrollees (Table 2.2). For both HI and SMI, the greatest increases in enrollment among the disabled occurred within the youngest and the oldest age groups. The rate of increase in enrollment was 2 to 3 times greater for those with end-stage renal disease (ESRD) only than for all disabled enrollees combined. HI and SMI enrollment increased faster among women than among men in both the disabled and ESRD-only groups. Similarly, the growth in enrollment of races other than white exceeded that of white persons in both the HI and SMI programs, and for both disabled and ESRD eligibles.

4. Trends in the Number of Medicaid Recipients, by Maintenance Assistance Status and Basis of Eligibility

Table 2.4 presents trend data on the number of Medicaid recipients by basis of eligibility and maintenance assistance status. Recipients are divided into two groups: (1) those who receive cash payments as well as Medicaid benefits, and (2) those who receive medical assistance only.^a Between 1973 and 1980, the total number of cash assistance recipients using Medicaid services increased at an average rate of 1.7 percent a year. The number of Medicaid recipients in the aged and blind cash assistance groups decreased during the same period at an annual rate of 1.2 percent. For all cash assistance groups, the highest rate of growth in the number of Medicaid recipients occurred among the disabled. Most of this increase occurred between 1973 and 1977, when the total number of disabled cash recipients increased by more than one-half. The number of children under 21 years of age and who comprise 49 percent of all cash-assistance Medicaid recipients, grew at an annual rate of 1.9 percent per year.

The number of Medicaid recipients not receiving cash assistance increased at a slightly slower rate than the cash assistance group, at 1.1 percent per year. Among medical-assistance-only recipients, the number of disabled and the adult recipients in the Aid to Families with Dependent Children (AFDC) program grew most rapidly, at rates of 7.3 and 7.1 percent per year, respectively.

5. Trends in Medicaid Recipients, by Age, Sex, and Race

Table 2.5 presents data on age, sex, and race of Medicaid recipients for fiscal years 1973 through 1980. Data were limited to States that reported. As indicated, the race of significant numbers of recipients is not known. Among recipients identified by age and sex, the number in the 65 years of age and older group decreased at an annual rate of 4.2 percent. All other age groups grew at rates ranging from 2.2 to 4.8 percent per year.

^aData on medically needy recipients, a subgroup of those recipients receiving medical assistance only, are available upon request for FY 1975 and later years, from the Bureau of Data Management and Strategy.

TABLE 2.1
Number of Medicare Enrollees by Type of Coverage,
and Number of Medicaid Recipients, 1966-1980
(thousands)

Medicare Enrollees by Type of Coverage				
Year ¹	Hospital Insurance and/or Supplementary Medical Insurance	Hospital Insurance	Supplementary Medical Insurance	Medicaid Recipients
1966	19,108.8	19,082.5	17,736.0	—
1967	19,521.0	19,493.9	17,893.0	—
1968	19,821.0	19,769.7	18,804.8	—
1969	20,102.7	20,014.2	19,194.7	—
1970	20,490.9	20,361.2	19,584.4	—
1971	20,914.9	20,742.3	19,974.7	—
1972	21,332.1	21,115.3	20,351.3	—
1973	23,545.4	23,301.1	22,490.5	19,622.2
1974	24,201.0	23,924.1	23,166.6	21,117.0
1975	24,958.6	24,640.5	23,904.6	22,222.7
1976	25,662.9	25,312.6	24,614.4	22,890.9
1977	26,457.9	26,093.9	25,363.5	22,920.5
1978	27,164.2	26,777.3	26,074.1	22,197.9
1979	27,858.7	27,459.2	26,757.3	21,540.0
1980	28,478.2	28,066.9	27,399.7	21,604.4
ACRG (%)	2.9	2.8	3.2	1.4

¹ Medicare data are as of July 1 of each year; Medicaid data are as of each fiscal year.

ACRG: Annual compound rate of growth.

"—" Data not available.

SOURCES: Elvira Fussell, "Persons Enrolled for Medicare, 1980," *Health Care Financing Notes*, Office of Research and Demonstrations, HCFA, September 1983, Pub. No. 03160. Medicaid figures for FY 1980 are from the *National Annual Medicaid Statistics*, unpublished.

FIGURE 2.1
Number of Medicare Enrollees and Medicaid Recipients, 1966-1980

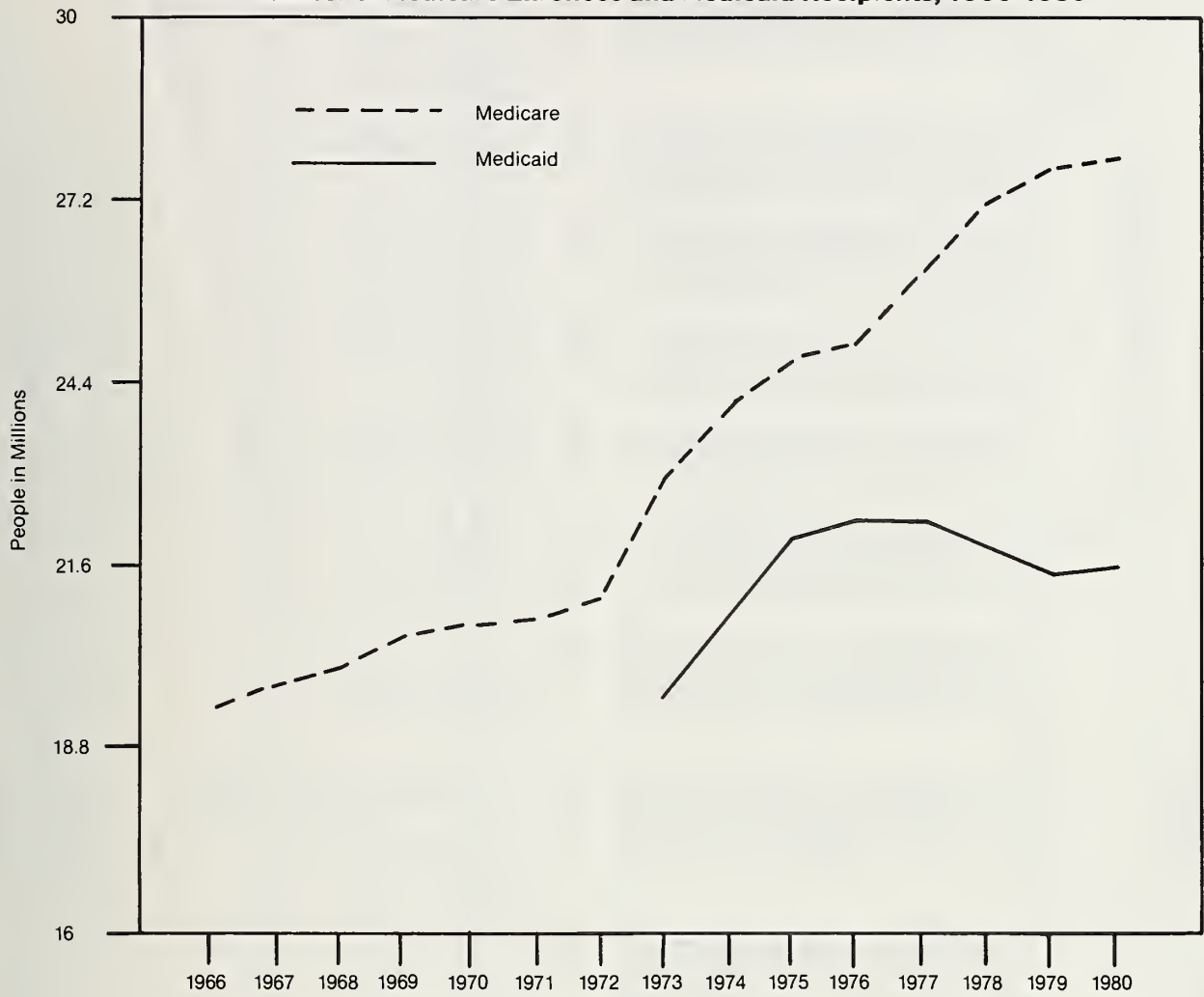


TABLE 2.2

Number of Aged Medicare Enrollees, by Type of Coverage, Age, Sex, and Race, July 1, 1966-1980
(thousands)

Year	Hospital Insurance						Supplementary Medical Insurance					
	Age			Sex			Age			Sex		
	Total	65-74	75+	Male	Female	White	Total	65-74	75+	Male	Female	Race ¹ White All Other Races
1966	19,082	11,990	7,092	8,133	10,950	17,042	17,736	11,186	6,550	7,534	10,202	15,938 1,264
1967	19,494	12,116	7,378	8,243	11,251	17,385	17,893	11,114	6,779	7,547	10,346	16,124 1,245
1968	19,770	12,158	7,611	8,318	11,452	17,632	18,805	11,561	7,244	7,878	10,927	16,877 1,368
1969	20,014	12,195	7,819	8,396	11,618	17,859	19,195	11,705	7,490	8,010	11,185	17,229 1,406
1970	20,361	12,316	8,045	8,507	11,855	18,187	19,584	11,873	7,711	8,132	11,452	17,576 1,472
1971	20,742	12,462	8,280	8,628	12,114	18,582	19,975	12,050	7,924	8,250	11,724	17,974 1,532
1972	21,115	12,641	8,474	8,744	12,371	18,930	20,351	12,248	8,104	8,360	11,991	18,325 1,557
1973	21,571	12,911	8,660	8,911	12,660	19,242	20,921	12,586	8,334	8,569	12,352	18,737 1,636
1974	21,996	13,182	8,814	9,005	12,991	19,601	21,422	12,925	8,496	8,694	12,727	19,149 1,704
1975	22,472	13,426	9,046	9,168	13,304	19,996	21,945	13,215	8,730	8,873	13,073	19,575 1,781
1976	22,920	13,691	9,229	9,324	13,596	20,382	22,446	13,529	8,917	9,047	13,399	19,995 1,845
1977	23,475	13,986	9,488	9,537	13,937	20,857	22,991	13,830	9,161	9,240	13,751	20,456 1,909
1978	23,984	14,259	9,725	9,728	14,256	21,289	23,531	14,119	9,412	9,436	14,094	20,904 1,978
1979	24,584	14,582	9,967	9,945	14,604	21,770	24,098	14,414	9,685	9,645	14,454	21,385 2,046
1980	25,104	14,894	10,210	10,156	14,948	22,244	24,680	14,726	9,954	9,868	14,813	21,876 2,114
ACRG (%)	2.0	1.6	2.6	1.6	2.2	1.9	2.4	2.0	3.0	1.9	2.7	2.3 3.7

ACRG: Annual compound rate of growth.

¹ Excludes enrollees whose race was unknown.

SOURCE: Health Care Financing Administration, Kathryn Barrett, "Medicare: Persons Enrolled in the Health Insurance Program, 1978-1979," *HCFA Program Statistics Report*, August 1982, Pub. No. 03142 and same publication 1980, in preparation.

TABLE 2.3

Number of Disabled Medicare Enrollees, by Type of Coverage, Age, Sex, and Race, July 1, 1973-1980
(thousands)

Year	Hospital Insurance							Supplementary Medical Insurance										
	Age				Sex			Age				Sex						
	Total	<35	35-44	45-54	55-64	Male	Female	White	All Other Races	Total	<35	35-44	45-54	55-64	Male	Female	White	All Other Races
All Disabled																		
1973	1,730.5	192.4	218.0	438.8	881.4	1,118.8	611.8	1,444.9	253.2	1,569.9	174.9	194.7	390.2	810.0	1,003.3	566.6	1,307.7	233.4
1974	1,928.1	220.2	237.6	481.4	988.9	1,232.1	696.0	1,602.3	287.1	1,745.0	194.0	211.0	428.0	912.0	1,102.0	643.0	1,446.0	263.1
1975	2,168.4	254.3	261.7	530.0	1,122.4	1,380.9	787.5	1,800.9	329.2	1,959.2	225.8	232.3	469.2	1,032.0	1,230.6	728.7	1,622.3	300.3
1976	2,392.2	288.3	285.8	574.0	1,244.1	1,514.3	877.8	1,983.2	370.9	2,168.5	258.3	255.7	510.2	1,144.3	1,352.8	815.7	1,792.6	339.6
1977	2,619.4	322.6	310.6	617.3	1,368.9	1,654.2	965.2	2,163.0	415.1	2,372.6	290.0	278.8	548.7	1,255.2	1,475.4	897.3	1,954.3	379.3
1978	2,793.2	344.8	335.4	646.5	1,466.5	1,763.0	1,030.2	2,299.1	447.8	2,543.2	311.9	303.1	579.2	1,349.0	1,581.8	961.3	2,088.9	411.0
1979	2,910.8	361.4	356.0	658.0	1,535.3	1,837.4	1,073.4	2,388.1	471.4	2,658.8	328.6	323.4	592.6	1,414.3	1,655.1	1,003.7	2,176.7	433.9
1980	2,963.2	371.2	369.5	657.5	1,565.0	1,870.5	1,092.6	2,422.2	486.7	2,719.2	339.7	337.1	596.3	1,446.1	1,694.6	1,024.7	2,218.2	449.8
ACRG (%)	8.0	9.8	7.8	5.9	8.5	6.7	8.6	7.7	9.8	8.2	9.9	8.2	6.2	8.6	7.8	8.8	7.8	9.8
Disabled—End-Stage Renal Disease Only																		
1973	6.4	2.2	1.4	1.7	1.1	3.4	3.0	4.6	1.2	6.3	2.1	1.3	1.7	1.1	3.3	2.9	4.5	1.2
1974	10.1	3.4	2.1	2.7	1.9	5.4	4.6	7.1	2.3	9.6	3.2	2.0	2.6	1.8	5.1	4.5	6.9	2.1
1975	12.7	4.3	2.4	3.3	2.6	6.7	6.0	8.6	3.2	12.1	4.1	2.3	3.2	2.6	6.4	5.7	8.2	3.0
1976	14.7	4.8	2.8	3.9	3.3	7.5	7.2	10.0	3.8	14.0	4.5	2.6	3.7	3.2	7.1	6.8	9.6	3.5
1977	16.5	5.1	3.0	4.4	3.9	8.4	8.2	11.3	4.4	15.5	4.8	2.8	4.2	3.7	7.8	7.7	10.7	4.1
1978	18.3	5.6	3.3	4.8	4.6	9.1	9.2	12.7	4.8	17.2	5.2	3.1	4.5	4.3	8.5	8.7	12.1	4.4
1979	23.6	7.4	4.3	5.9	5.9	12.0	11.6	16.3	6.3	22.4	7.0	4.1	5.7	5.6	11.4	11.0	15.6	5.8
1980	28.3	8.8	5.2	7.0	7.4	14.5	13.8	19.2	7.9	27.0	8.3	5.0	6.7	7.1	13.9	13.2	18.5	7.4
ACRG (%)	23.7	21.9	20.6	22.4	31.1	23.0	24.4	22.6	30.9	23.1	21.7	21.2	21.6	30.5	22.8	24.2	22.4	29.7

TABLE 2.4

Number of Medicaid Recipients, by Maintenance Assistance Status and Basis of Eligibility, 1973-1980
(thousands)

Year	Cash Assistance							Medical Assistance Only							Other Title XIX
	Total ¹	Age 65+	Blind	Disabled	Children Under 21	Adults in AFDC	Other Title XIX ²	Total ¹	Age 65+	Blind	Disabled	Children Under 21	Adults in AFDC		
1973	14,519.9	2,226.9	83.6	1,425.4	7,017.3	3,616.7	150.0	5,102.3	1,268.6	17.7	378.7	1,641.4	449.7	1,346.2	
1974	15,969.1	2,510.3	99.9	1,810.8	7,693.9	3,727.8	126.3	5,147.3	1,191.4	29.2	386.8	1,652.2	562.9	1,324.9	
1975	16,805.0	2,443.6	84.9	1,830.3	8,393.3	4,052.9	NA	5,417.7	1,215.8	23.7	449.9	1,286.8	577.1	1,864.4	
1976	17,201.0	2,408.3	76.7	1,984.8	8,512.0	4,219.3	NA	5,689.9	1,236.2	17.5	512.2	1,427.1	591.0	1,905.9	
1977	17,103.4	2,408.7	76.1	2,178.1	8,361.8	4,078.5	NA	5,817.1	1,149.7	9.8	519.4	1,366.6	737.6	2,034.1	
1978	16,622.6	2,194.0	64.9	2,101.4	8,247.7	4,014.6	NA	5,575.3	1,184.5	9.8	535.7	1,252.3	688.0	1,905.0	
1979	15,964.8	2,070.9	66.7	2,028.0	7,923.8	3,875.3	NA	5,575.3	1,283.2	13.5	633.2	1,219.1	678.1	1,748.2	
1980	16,312.5	2,046.8	76.6	2,123.7	8,003.8	4,007.3	NA	5,511.5	1,369.6	15.7	618.8	1,278.7	726.2	1,507.4	
ACRG (%)	1.7	-1.2	-1.2	5.9	1.9	1.5	NA	1.1	1.1	-1.7	7.3	-3.5	7.1	1.6	

¹ Totals for each year include estimated recipient counts for nonreporting States.

² Cash assistance to other Title XIX recipients was phased out after 1974.

ACRG: Annual compound rate of growth.

NA Not applicable.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

TABLE 2.5
Number of Medicaid Recipients, by Age, Sex, and Race, 1973-1980¹
(thousands)

Year	Age					Sex		Race		
	Total	<6	6-20	21-64	65+	Male	Female	White	All Other Races	Unknown
1973	19,622.2	2,890.4	5,943.6	6,292.8	4,495.4	7,222.9	12,399.3	—	—	—
1974	21,116.4	3,410.3	6,717.1	7,304.2	3,684.8	7,342.2	13,774.2	—	—	—
1975	22,222.7	3,366.7	7,329.0	7,735.7	3,791.2	7,762.4	14,460.3	8,315.5	6,165.9	7,741.3
1976	22,890.9	3,596.2	7,732.5	7,869.9	3,692.3	8,000.4	14,890.5	8,383.3	6,620.3	7,887.3
1977	22,920.5	3,504.5	7,359.8	8,267.4	3,788.8	8,065.7	14,854.8	8,471.9	6,421.3	8,027.3
1978	22,197.9	3,438.5	7,241.0	7,957.9	3,560.5	7,720.4	14,477.5	8,207.7	6,313.3	7,676.9
1979	21,540.0	3,401.2	6,856.2	7,511.0	3,771.7	7,474.4	14,065.6	8,043.5	7,125.9	6,370.6
1980	21,604.4	4,017.5	6,906.3	7,350.0	3,330.5	7,702.3	13,902.1	7,846.6	6,275.9	7,481.8
ACRG (%)	1.4	4.8	2.2	2.2	-4.2	.9	1.6	-1.2	.4	-.7

¹ A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to use an estimation technique with confidence. Consequently, ACRG for race categories should be used with caution because growth could occur simply because race had been reported more frequently, rather than because of an actual change in racial composition.
ACRG: Annual compound rate of growth.
"—": Data not available.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

B. Expenditures

1. Trends in Medicare Reimbursements and Medicaid Payments

Table 2.6 and Figure 2.2 present data on Medicare reimbursements and Medicaid payments. Total Medicare reimbursements grew at an average annual rate of 17.2 percent between 1967 and 1980. SMI reimbursements increased more rapidly than HI reimbursements. The large increase in total reimbursements between 1973 and 1974 reflects the extension of Medicare coverage to the disabled. The entry of the disabled also accelerated the rate of increase in SMI reimbursements, largely because of the rising cost of end-stage renal dialysis patients with SMI coverage. The average cost of a single dialysis treatment is about \$150, and most ESRD users require three treatments a week. Thus, a regular schedule of dialysis costs over \$20,000 a year for the average user.

Medicaid payments also increased throughout the period covered. Payments for the aged, blind, and disabled grew fastest. As indicated in Figure 2.2, annual percentage increases in Medicare reimbursements were higher than those for Medicaid payments.

Figures 2.3 and 2.4 show changes over time in the distribution of Medicare reimbursements and Medicaid payments by type of service covered. As shown in Figure 2.4, the proportion of total Medicaid payments for inpatient hospital services decreased from 30.8 percent in 1973 to 26.9 percent in 1980. Conversely, the proportion of Medicare reimbursements for inpatient hospital services increased slightly, from 62.7 percent in 1967 to 66.4 percent in 1980. There was a small decrease over the same period (from 28.9 percent in 1967 to 24.9 percent in 1980) in the proportion of all Medicare reimbursements made for physicians' and other medical services. Physician payments as a proportion of total Medicaid payments also decreased, from 10.7 percent in 1973 to 8.0 percent in 1980. Reimbursements for outpatient services as a proportion of all Medicare reimbursements increased six-fold between 1967 and 1980, from 0.9 percent to 5.8 percent. Medicaid payments for outpatient services increased at a much slower rate, from 3.1 percent in 1973 to 4.7 percent in 1980. For home health agency services, Medicare reimbursements rose from 1.0 percent to 1.9 percent between 1967 and 1980. The proportion of Medicare reimbursements for skilled nursing facility services decreased markedly between 1967 (6.5 percent) and 1980 (1.0 percent). In contrast, Medicaid payments for nursing home care rose from 34.9 percent in 1973 to 42.5 percent in 1980. As these charts show, long-term care services accounted for the largest proportion of total Medicaid payments, and acute care services were responsible for the largest share of total Medicare reimbursements.

2. Trends in Medicare Reimbursements, 1966-1980

Table 2.7 provides trend data on Medicare reimbursements by type of coverage and type of enrollee. Between 1968 and 1980, successive increases in reimbursements for each entitlement group resulted in a more than six-fold increase in total reimbursements. A portion of this increase is, of course, because of the extension of Med-

icare coverage to disabled persons in 1973. Reimbursements for the disabled grew nearly twice as fast as reimbursements for the aged, increasing to 13.3 percent of total reimbursements in 1980, from 8.7 percent in 1974.

3. Distribution of Medicare Enrollees and Reimbursements per Enrollee

Figure 2.5 shows the percent of Medicare enrollees and reimbursements accounted for by varying levels of reimbursement. A small proportion of "high-cost" enrollees accounted for a very large share of reimbursements in both the aged and disabled groups. Among the aged in 1980, those reimbursed for \$5,000 or more of services (though representing only 6.4 percent of those enrollees) accounted for 61.4 percent of all Medicare reimbursements for aged enrollees. At the other extreme, 39.5 percent of aged enrollees received no reimbursements during the year, either because (1) they had no covered Medicare charges; (2) they did not exceed Medicare deductibles; (3) their bills exceeded the deductibles but they did not file a claim; or (4) they received covered services without charge. Another 35.7 percent of aged enrollees received less than \$500 in reimbursements.

Comparable figures for the disabled provide an even more graphic example of how medical insurance spreads the risk of illness. Although representing only 7.5 percent of all disabled enrollees, those in the \$5,000 and over group accounted for 71.6 percent of all Medicare reimbursements for disabled enrollees. The fact that "high-cost" users account for a larger share of reimbursements in the disabled group than in the aged group reflects the significantly greater representation of ESRD patients among disabled enrollees.

4. Trends in Medicaid Payments

As shown in Table 2.8, Medicaid payments grew fastest for services provided to the disabled, both in the cash-assistance group and in the medical-assistance-only group. The slowest rate of increase in payments occurred for children under 21 years of age not receiving cash assistance. This contrasts sharply with the relatively rapid growth in payments for children receiving cash assistance. As derived from Table 2.4, however, the number of children not receiving cash assistance declined by 22 percent during this period.

Figure 2.6 charts trends in Medicaid payments for long-term care, inpatient hospital services, and all other Medicaid services (Muse, 1982). As the figure shows, payments for long-term care services have increased steadily since FY 1973. Inpatient hospital services also have increased, but less rapidly. The remaining Medicaid services have increased at slower rates than either hospital or long-term care services. Payments for physicians' and clinic services increased \$1.0 and \$.1 billion, respectively, between FY 1973 and FY 1980. As a percent of total payments, however, both decreased (by 2.7 and 1.3 percent, respectively) during the same period. Similarly, payments for prescribed drugs grew \$.7 billion during the period, but decreased 1.3 percent as a proportion of total payments.

TABLE 2.6

Medicare Reimbursements by Type of Coverage, and Medicaid Payments by Basis of Eligibility, 1966-1980
(millions)

Year	Medicare Reimbursements ¹				Medicaid Payments				
	Coverage			Percent Change in Total Over Previous Year	Basis of Eligibility				Percent Change in Total Over Previous Year
	Total	Hospital Insurance	Supplementary Medical Insurance		Total	AFDC	ABD ²	Other	
1966	\$ 1,019	\$ 891	\$ 128	NA	—	—	—	—	—
1967	4,549	3,353	1,197	346.4	—	—	—	—	—
1968	5,697	4,179	1,518	25.2	—	—	—	—	—
1969	6,603	4,739	1,865	15.9	—	—	—	—	—
1970	7,099	5,124	1,975	7.5	—	—	—	—	—
1971	7,868	5,751	2,117	10.8	—	—	—	—	—
1972	8,643	6,318	2,325	9.9	—	—	—	—	—
1973 ³	9,583	7,057	2,526	10.9	\$ 8,640	\$ 2,872	\$ 5,315	\$452	NA
1974	12,418	9,099	3,318	30.2	9,983	5,093	6,159	425	15.5
1975	15,588	11,315	4,273	24.9	12,292	4,063	7,606	623	23.1
1976	18,420	13,340	5,080	18.2	14,135	4,598	8,827	710	15.0
1977	21,774	15,737	6,038	18.2	16,277	4,978	10,378	909	15.2
1978	24,934	17,682	7,252	14.5	17,966	5,343	11,646	974	10.4
1979	29,331	20,623	8,708	17.6	20,474	5,700	13,879	900	14.0
1980	35,699	25,064	10,635	21.7	23,301	6,543	15,845	914	13.8
ACRG (%)	17.2 ⁴	16.7 ⁴	18.3 ⁴	NA	15.5	12.1	17.3	12.2	NA

¹ Medicare data are calendar years; Medicaid are fiscal years.

² Aged, Blind, and Disabled.

³ Disabled enrollees were covered by Medicare on July 1, 1973.

⁴ ACRG computed for 1967 through 1980 because the 1966 figures are for July through December.

ACRG: Annual compound rate of growth.

"—" Data not available.

NA Not applicable.

SOURCES: The Board of Trustees, Federal Hospital Insurance Fund, *1981 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, July 8, 1981, p.26; Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1981 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, July 8, 1981, p. 22; and the Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. Medicaid figures for FY 1980 are from *Annual Medicaid Statistics*, unpublished.

FIGURE 2.2
Total Medicare Reimbursements and Medicaid Payments, 1966-1980

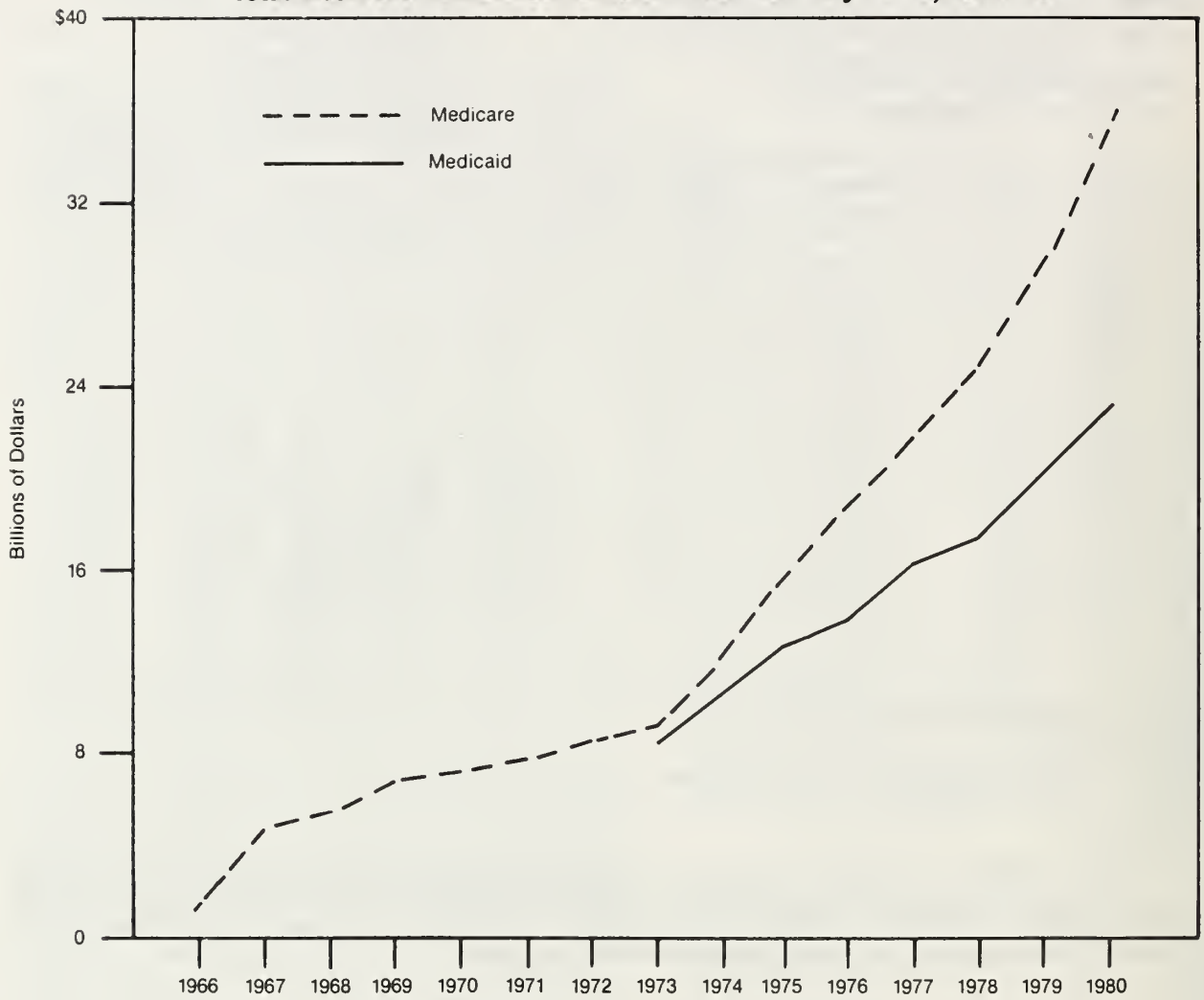


FIGURE 2.3
Distribution of Medicare Reimbursements, by Type of Service;
Calendar Years 1967 and 1980

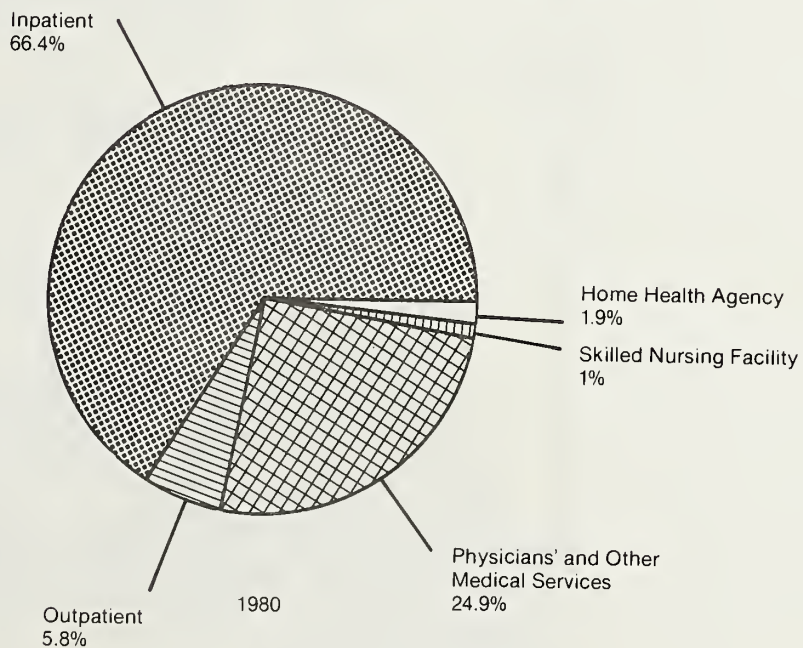
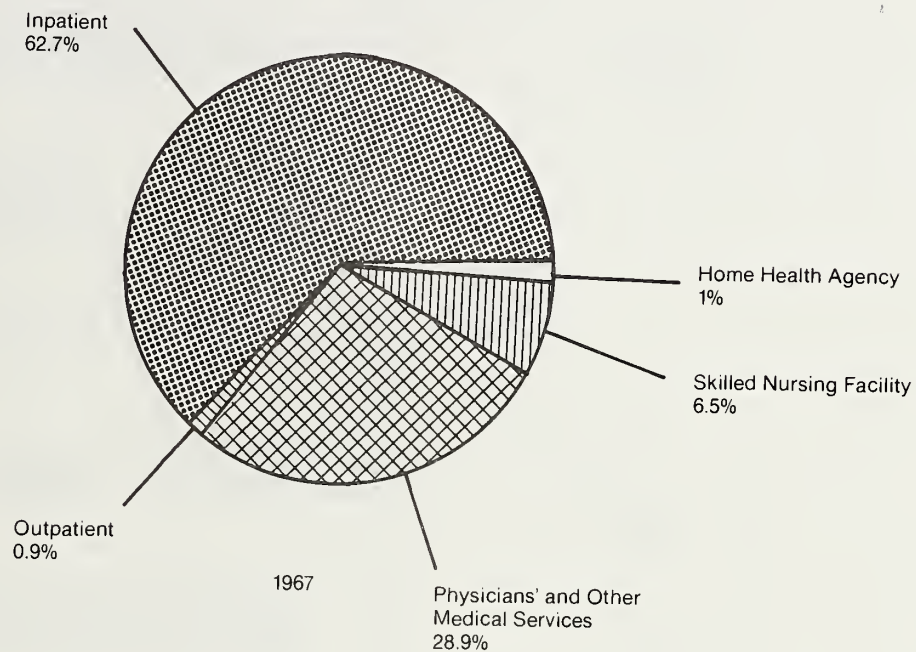


FIGURE 2.4
Distribution of Medicaid Payments, by Type of Service,
Fiscal Years 1973 and 1980

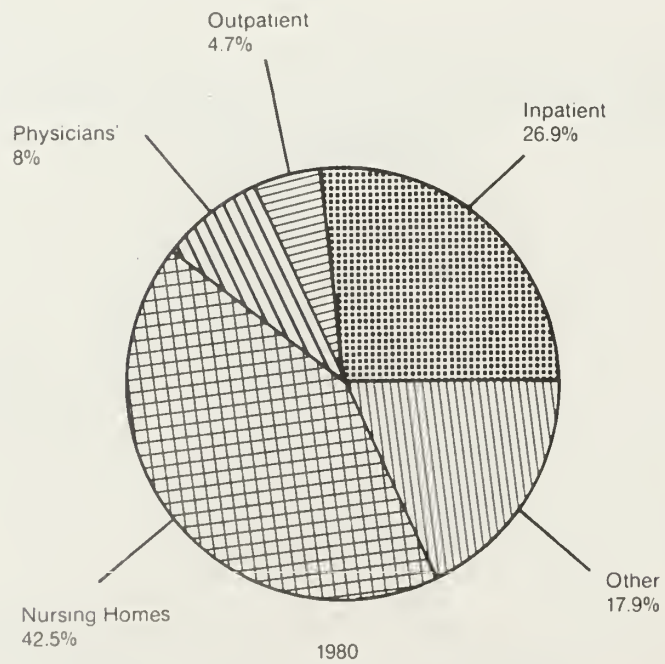
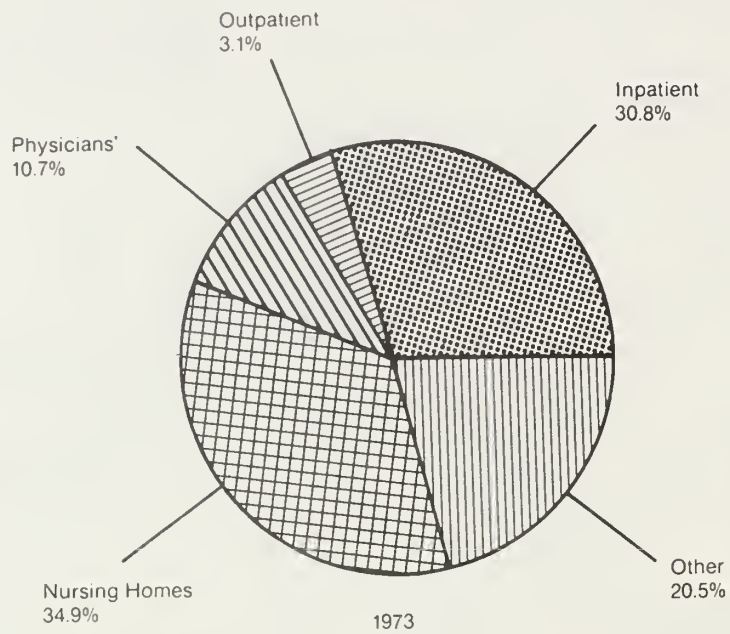


TABLE 2.7
Medicare Reimbursements, 1966-1980¹
(millions)

Year	Hospital Insurance and Supplementary Medical Insurance				Hospital Insurance				Supplementary Medical Insurance			
	Total Reim- bursements	Aged ²	Disabled ³	ESRD ⁴	All HI Enrollees	Aged ²	Disabled ³	ESRD ⁴	All SMI Enrollees	Aged ²	Disabled ³	ESRD ⁴
7/66-12/67	\$ 5,145.2	\$ 5,145.2	NA	NA	\$ 3,839.9	\$ 3,839.9	NA	NA	\$ 1,305.3	\$1,305.3	NA	NA
1968	5,289.5	5,289.5	NA	NA	3,766.9	3,766.9	NA	NA	1,522.6	1,522.6	NA	NA
1969	6,267.6	6,267.6	NA	NA	4,597.4	4,597.4	NA	NA	1,670.3	1,670.3	NA	NA
1970	6,572.0	6,572.0	NA	NA	4,740.3	4,740.3	NA	NA	1,831.6	1,831.6	NA	NA
1971	7,354.4	7,354.4	NA	NA	5,358.2	5,358.2	NA	NA	1,996.2	1,996.2	NA	NA
1972	8,019.4	8,019.4	NA	NA	5,835.7	5,835.7	NA	NA	2,183.7	2,183.7	NA	NA
1973	—	9,038.7	—	—	—	6,674.3	—	—	—	2,364.3	—	—
1974	11,238.0	10,257.5	\$ 980.5	\$ 184.4	8,118.4	7,454.4	\$ 664.0	\$44.6	3,119.6	2,803.1	\$ 316.5	\$139.8
1975	14,548.5	13,056.1	1,492.4	346.8	10,519.1	9,537.4	981.8	93.7	4,029.4	3,518.7	510.6	253.1
1976	17,619.0	15,636.5	1,982.5	492.0	12,793.9	11,495.8	1,298.1	134.3	4,825.1	4,140.7	684.4	357.7
1977	20,476.8	18,014.7	2,462.1	614.0	14,709.9	13,116.3	1,593.6	167.4	5,766.9	4,898.4	868.5	446.6
1978	23,542.7	20,579.1	2,963.6	744.0	16,630.3	14,740.7	1,889.7	196.6	6,912.4	5,838.4	1,073.9	548.1
1979	27,699.1	24,005.0	3,694.1	950.4	19,257.9	16,940.4	2,317.4	252.4	8,441.2	7,064.5	1,376.7	698.0
1980	33,724.7	29,224.2	4,500.5	1,207.0	23,194.2	20,404.1	2,790.1	330.2	10,530.5	8,820.1	1,710.4	876.8
ACRG (%)	16.7 ⁵	15.3 ⁵	28.9	36.8	16.4 ⁵	15.1 ⁵	27.0	39.6	17.5 ⁵	15.8 ⁵	32.5	35.8

¹ Preliminary data unadjusted for claims paid after data compilation. These data do not correspond to data on Table 2.6 primarily because Trust Fund data are based on interim reimbursements and retroactive adjustments made to institutional providers.

² For all enrollees aged 65 and over, including those with end-stage renal disease.

³ For all aged and disabled enrollees with end-stage renal disease.

⁴ For all aged and disabled enrollees with end-stage renal disease.

⁵ ACRG computed for 1968 through 1980.

ESRD: End-stage renal disease.

ACRG: Annual compound rate of growth.

NA: Not applicable.

“—”: Data not available.

SOURCE: Health Care Financing Administration, *Medicare: Reimbursements by State and County*, annual issues for 1966-1980.

FIGURE 2.5
Percent Distribution of Enrollees
and Amounts Reimbursed Under Hospital Insurance
and/or Supplementary Medical Insurance, 1980

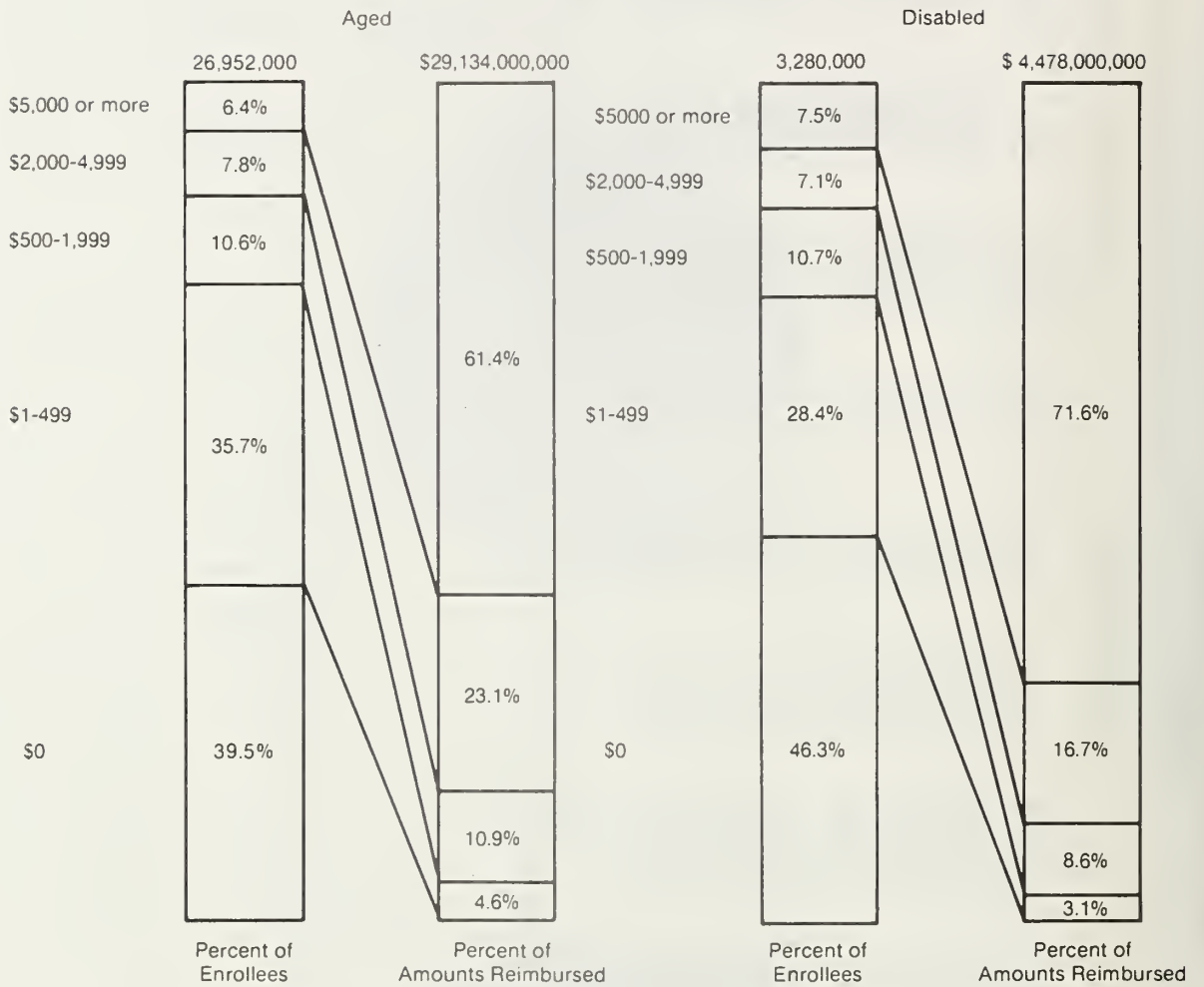


TABLE 2.8

Medicaid Payments, by Maintenance Assistance Status and Basis of Eligibility, 1973-1980
(millions)

Year	Cash Assistance					Medical Assistance Only ⁴					Adults in AFDC	Other Title XIX		
	Total ¹	Age 65+	Blind	Disabled	Children Under 21	Total ¹	Age 65+	Blind	Disabled	Children Under 21				
1973	\$ 4,736.5	\$ 985.0	\$46.4	\$1,335.6	\$1,048.5	\$1,277.8	\$44.3	\$3,903.3	\$2,250.5	\$18.5	\$ 680.5	\$377.6	\$168.3	\$407.9
1974	5,640.8	1,177.5	54.5	1,605.2	1,319.6	1,447.3	36.6	4,342.1	2,513.7	25.3	783.1	374.6	257.1	388.2
1975	6,624.7	1,371.9	56.5	1,831.6	1,634.4	1,730.3	NA	5,667.7	3,277.3	27.0	1,042.1	415.8	282.7	622.8
1976	7,657.6	1,456.9	55.2	2,282.4	1,903.2	1,960.0	NA	6,477.0	3,734.8	31.0	1,267.1	449.7	284.9	709.5
1977 ³	9,214.8	1,894.2	67.6	2,964.5	2,083.4	2,205.1	NA	7,062.2	3,935.5	31.5	1,492.3	368.2	324.9	909.8
1978 ³	10,004.9	2,020.2	68.7	3,279.1	2,310.9	2,326.0	NA	7,960.7	4,401.1	33.5	1,845.5	365.9	340.7	974.0
1979	10,726.0	2,076.6	75.6	3,671.2	2,434.4	2,468.3	NA	9,747.5	5,570.3	47.6	2,432.6	430.0	367.5	899.5
1980	12,245.9	2,217.1	90.4	4,272.9	2,682.0	2,953.6	NA	11,055.1	6,469.6	51.8	2,742.1	458.3	418.8	913.9
ACRG (%)	14.5	12.3	10.0	18.1	14.4	12.7	NA	16.0	16.3	15.8	22.3	2.8	13.9	12.2

¹ Totals for each year include estimated payments for nonreporting States. Due to rounding, "Total" may not equal the sum of payments by basis of eligibility.

² Cash assistance to other Title XIX recipients was phased out and therefore not reported after 1975.

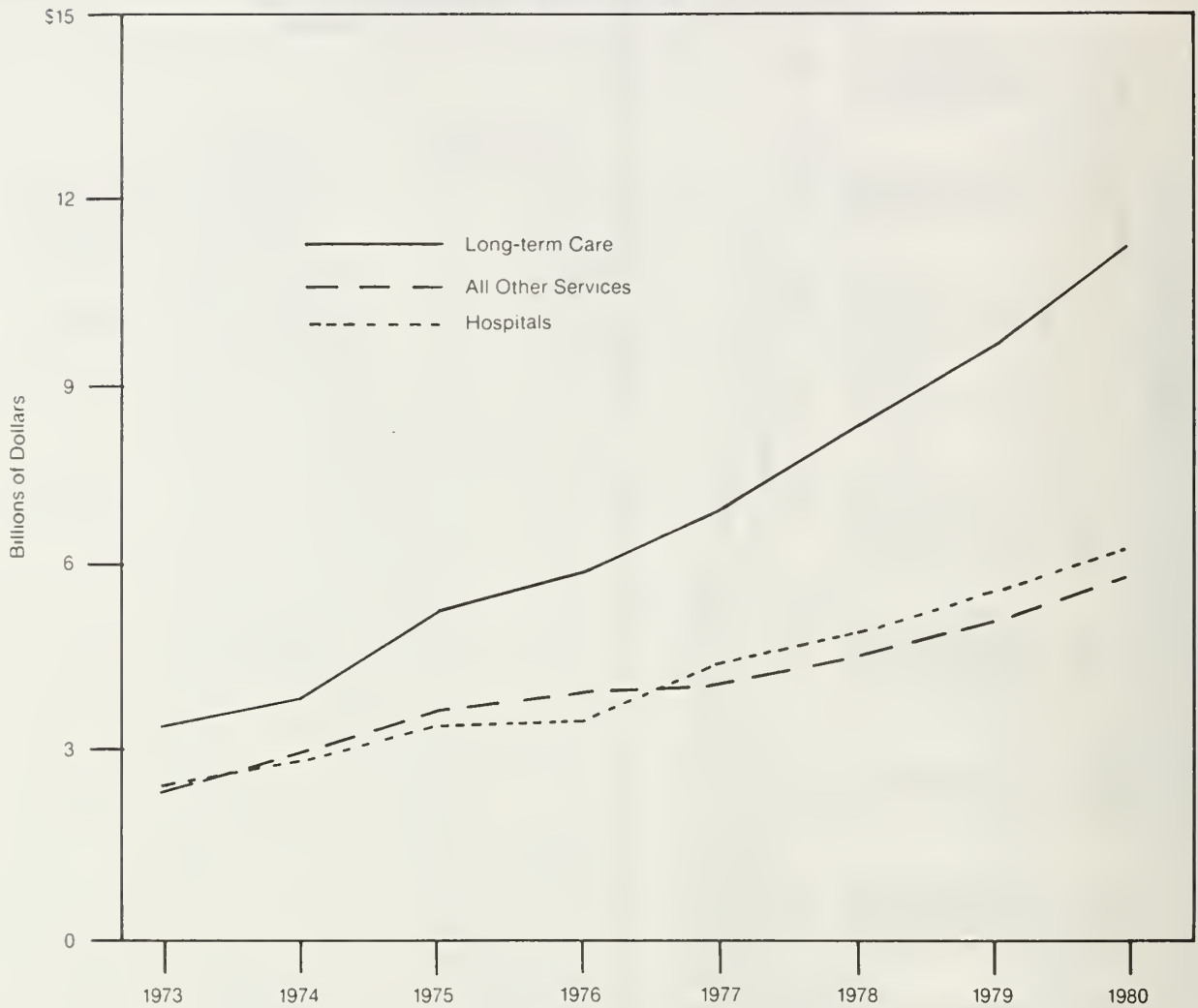
³ Data for 1977 and 1978 have been adjusted to distribute small amounts of payments on behalf of persons whose basis of eligibility was unknown.

⁴ This category includes categorically needy recipients who do not receive cash payments and medically needy recipients.

ACRG: Annual compound rate of growth.
NA Not applicable.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

FIGURE 2.6
Medicaid Vendor Payments:
Hospital, Long-Term Care,
and All Other Services, Fiscal Years 1973-1980



5. Trends in Medicaid Payments by Age, Sex, and Race

Table 2.9 reports expenditures by age, sex, and race of recipients. As in Table 2.5, recipients' race is not reported by some States. Among recipients for whom data are available, the table shows a range in the growth of expenditures from 14.1 percent for those over 64 years of age, to 18.2 percent for children under 6 years of age. Payments on behalf of male and female recipients grew at approximately equal rates.

6. Medicaid Eligibility Group and Payment Relationships

As is the case with Medicare, a small number of recipients consume a disproportionate share of Medicaid payments. Figure 2.7 shows the share of total recipients and total payments accounted for by each of five eligibility groups. In FY 1980, the aged accounted for less than 16 percent of all recipients but more than 37 percent of all payments. Similarly, the blind and disabled accounted for only 12.3 percent of all recipients but 30.3 percent of all payments. Together, these groups accounted for 27.9 percent of all recipients and 67.7 percent of all payments. At the opposite end of the spectrum are children in AFDC families who accounted for 43 percent of all recipients but only 13.6 percent of all payments.

Although no national level data exist, it has been estimated that less than 6 percent of all Medicaid recipients, primarily aged and disabled recipients, account for over 25 percent of all expenditures.

C. Use of and Expenditures for Short-Stay Hospital and Physicians' Services

Table 2.10 presents data on Medicare and Medicaid short-stay inpatient hospital use, including discharges, covered days of care, reimbursements for Medicare enrollees, and payments for Medicaid recipients. Disabled Medicare enrollees exhibited the highest rates of growth in discharges, days of care, and reimbursements. This reflects the rapid rate of increase in enrollment of disabled persons (Table 2.3).

Days of care for disabled Medicare enrollees grew 12.4 percent per year. Days of care for aged Medicare enrollees grew much more slowly, at 2.3 percent per year. Medicare reimbursements for short-stay hospital services grew at a faster rate for the aged (16.0 percent) and the disabled (28.8 percent) than Medicaid payments (13.4 percent).

Table 2.11 reports data on Medicare reimbursements and Medicaid payments for physicians' services. Similar to inpatient hospital services, physician reimbursements for disabled Medicare enrollees grew the fastest, 30.0 percent a year. Medicaid payments for physicians' services grew the slowest, 10.6 percent a year.

Figures 2.8 and 2.9 display these trends in Medicare reimbursements and Medicaid payments for inpatient hospital and physicians' services. As shown in each figure, Medicaid payments have been growing more slowly than Medicare reimbursements in recent years. To some extent, this reflects the declining number of Medicaid recipients since 1977 (Figure 2.1).

D. Trends for Selected Medicare Services

Figure 2.10 shows reimbursement trends for skilled nursing care, outpatient services, and home health services. The trend-line for outpatient care illustrates the sharp increase in reimbursements that occurred after the entry of the disabled in 1973. Tables 2.12, 2.13, and 2.14 present more detailed data on these trends.

1. Skilled Nursing Facility Services

Table 2.12 presents data on the use of and reimbursements for skilled nursing facility (SNF) services. The data are based on bills for services incurred in a calendar year. Among aged enrollees, the number of covered days of SNF care reimbursed decreased by 62 percent between 1969 (the first year data were collected) and 1972. From 1973 through 1980, the number of covered days fluctuated up and down with no discernable trend. Between 1969 and 1980, the average annual rate of decrease for covered days was 6.9 percent for the aged. The decline resulted from administrative limitations on the Medicare SNF benefit which, by law, is targeted to enrollees requiring skilled nursing services but not custodial care.

In 1980, the disabled accounted for only 3.6 percent of total Medicare covered days in SNF's. Between 1974 (the first full year of coverage) and 1980, the number of covered days of care used by the disabled increased at an average annual rate of 1.3 percent. Among the aged, the decline in covered days of care resulted in declines in reimbursement between 1969 and 1972, and only in 1973 did reimbursements begin to rise. By 1980, SNF reimbursements for the aged were still only slightly above that of 1969. In contrast, reimbursements for the disabled rose at an average annual rate of 8.4 percent between 1974 and 1980.

2. Outpatient Services

For both aged and disabled enrollees, reimbursements for outpatient care grew more rapidly than for any other service (Table 2.13 and Figure 2.10). The disabled accounted for more than one-third of outpatient reimbursements, again reflecting the important role of the ESRD population within the SMI program.

3. Home Health Services

Table 2.14 presents data on the use of and reimbursements for home health services between 1969 and 1980. The rapid increase since 1972 in both visits and reimbursements partly reflects the 1972 Amendments which (1) extended coverage to the disabled and to those with end-stage renal disease, and (2) expanded payments and coverage of home health care. Overall, reimbursements grew about 2.3 times faster than the number of visits.

E. Trends for Selected Medicaid Services

Figure 2.11 shows trends in Medicaid payments for SNF's and intermediate care facilities (ICF's). Trends in Medicaid payments for hospital outpatient services, home health services, and drug prescriptions are shown in Figure 2.12. Detailed information on changes in these services is presented in Tables 2.15 through 2.20.

TABLE 2.9
Medicaid Payment, by Age, Sex, and Race, 1973-1980¹
(millions)

Year	Total	Age				Sex		Race		
		<6	6-20	21-64	65+	Male	Female	White	All Other Races	Unknown
1973	\$ 8,640	\$ 537.4	\$1,067.9	\$3,696.2	\$3,338.5	\$2,886.6	\$ 5,753.4	—	—	—
1974	9,983	601.0	1,335.7	4,140.0	3,906.3	3,235.5	6,747.5	—	—	—
1975	12,292	720.3	1,719.7	5,042.2	4,809.9	3,924.8	8,367.2	\$ 5,944.2	\$2,646.3	\$3,701.5
1976	14,135	883.4	2,052.4	5,856.1	5,343.0	4,550.1	9,584.9	6,666.3	3,131.7	4,337.0
1977	16,277	1,002.7	2,465.0	6,881.9	5,926.5	5,286.8	10,990.2	8,153.4	3,554.4	4,569.3
1978	17,966	1,148.0	2,522.4	7,533.1	6,762.4	5,910.8	12,055.2	9,039.9	4,032.4	4,893.7
1979	20,474	1,244.8	2,712.8	8,523.3	7,995.1	6,678.6	13,795.4	11,053.1	5,272.0	4,148.9
1980	23,301	1,735.3	3,283.6	9,868.4	8,413.7	7,798.9	15,502.2	12,354.8	4,894.3	6,051.9
ACRG (%)	15.2	18.2	17.4	15.1	14.1	15.3	15.2	15.8	13.1	10.3

¹ A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to use an estimation technique with confidence. Consequently, ACRG for race categories should be used with caution since growth could occur simply because race had been reported more frequently, rather than because of an actual change in racial composition.

ACRG: Annual compound rate of growth.

"—" Data not available.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. FY 1980 are from *Annual Medicaid Statistics*, unpublished.

TABLE 2.10
Use of Short-Stay Hospitals Under Medicare and Medicaid, 1967-1979

Year ²	Discharges (thousands)			Days of Care ¹ (thousands)			Medicare Reimbursements (millions)		Medicaid Payments (millions)
	Medicare		Medicaid	Medicare		Medicaid	Aged	Disabled	
	Aged	Disabled		Aged	Disabled				
1967	5,228	NA	—	68,487	NA	—	\$2,760	NA	—
1968	5,641	NA	—	75,589	NA	—	3,509	NA	—
1969	5,852	NA	—	77,246	NA	—	4,085	NA	—
1970	5,951	NA	—	75,578	NA	—	4,481	NA	—
1971	6,090	NA	—	74,298	NA	—	5,036	NA	—
1972	6,380	NA	—	75,284	NA	—	5,576	NA	—
1973	6,751	—	4,152	77,637	—	30,456	6,245	—	\$2,660
1974	7,033	604	4,198	79,770	6,378	32,676	7,209	\$ 621	2,887
1975	7,285	724	4,508	80,135	7,370	34,122	8,859	876	3,411
1976	7,607	863	4,549	82,916	8,661	31,623	10,589	1,183	3,938
1977	7,963	984	5,106	86,662	9,991	35,571	12,627	1,545	4,603
1978	8,280	1,076	5,871	88,552	10,730	35,313	14,422	1,857	4,985
1979 ³	8,541	1,165	6,060	89,532	11,426	33,420	16,312	2,201	5,650
ACRG (%)	4.2	14.0	6.5	2.3	12.4	1.6	16.0	28.8	13.4

¹ For Medicare, Days of Care includes only days covered by Medicare, i.e., a day of inpatient hospital care during which services covered by Medicare and determined to be medically necessary by the Professional Standards Review Organization or the Utilization Review Committee were furnished to a person eligible for Hospital Insurance (HI) benefits.

² Medicare data are for calendar years; Medicaid are for fiscal years.

³ Medicare data based on discharge stay records recorded June 1981. Data for 1979 are understated by about 2 percent compared to earlier years.

ACRG: Annual compound rate of growth.

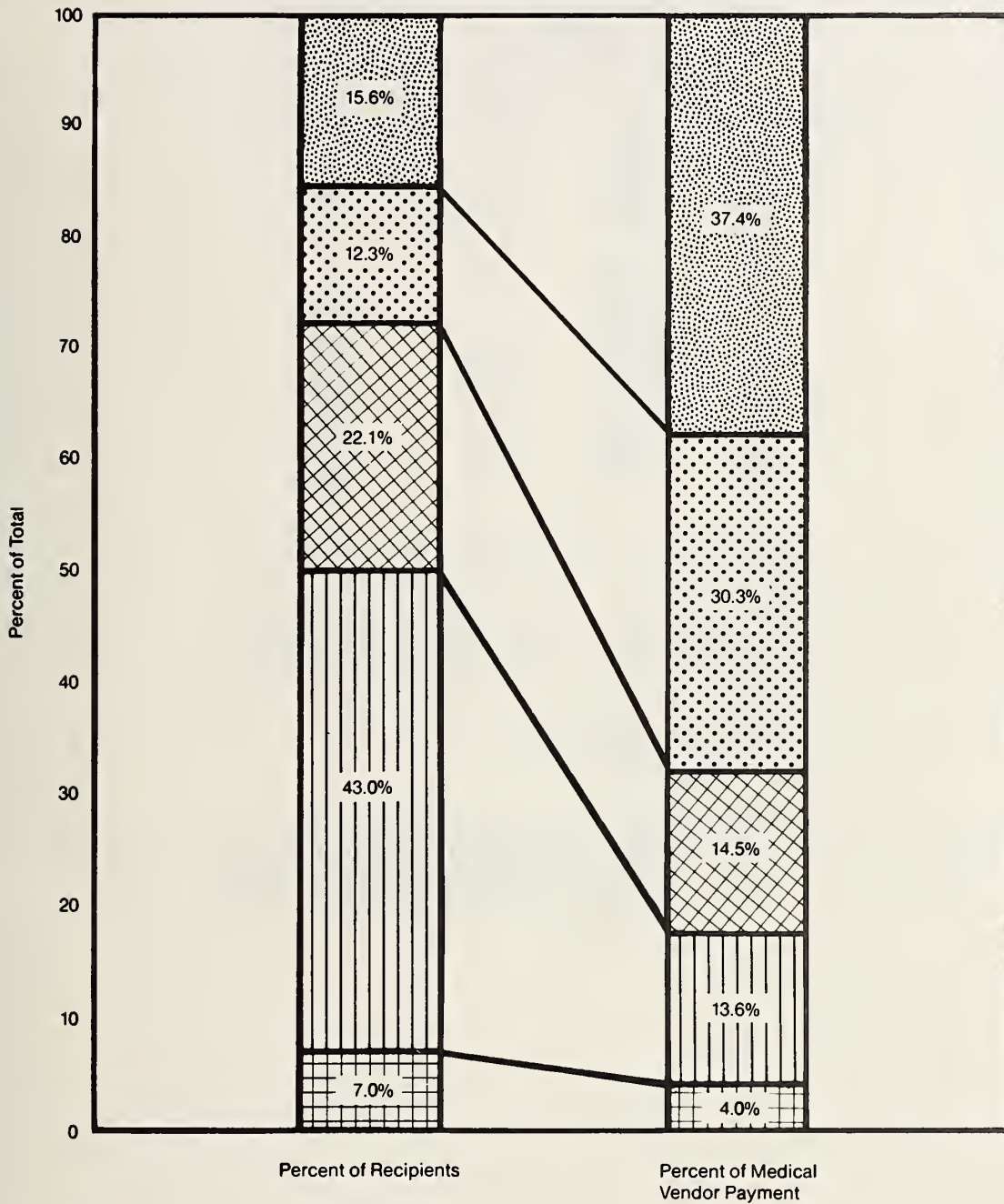
"—" Data not available.

NA: Not applicable.

SOURCES: Charles Helving, "Ten Years of Short-Stay Hospital Utilization and Costs Under Medicare: 1967-1976," *Health Care Financing Research Report* (August 1980), HCFA Pub. No. 03053, and unpublished data, Medicare Program Statistics Branch, Office of Research and Demonstrations, HCFA; Office of Research and Demonstrations, HCFA, *National Annual Medical Statistics*, Fiscal Years 1973 through 1979. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

FIGURE 2.7

Percent Distribution of Recipients and Medicaid Medical Vendor Payments, by Basis of Eligibility, 1980



-  Aged
-  Blind and Disabled
-  Adults in AFDC Families
-  Children in AFDC Families
-  Other Title XIX

TABLE 2.11
Medicare Reimbursements for Physicians' and Other
Medical Services, and Medicaid Payments
for Physicians' Services, 1966-1980
(millions)

Year ¹	Medicare Reimbursements ²		Medicaid Payments
	Aged	Disabled	
1966	\$ 431.0	NA	—
1967	1,223.8	NA	—
1968	1,437.0	NA	—
1969	1,609.0	NA	—
1970	—	NA	—
1971	1,847.7	NA	—
1972	2,028.8	NA	—
1973	2,112.0	—	\$ 925.9
1974	2,534.0	\$206.2	1,083.4
1975	3,050.0	295.2	1,247.7
1976	3,633.0	389.1	1,388.6
1977	4,177.0	481.5	1,525.5
1978	5,145.0	556.5	1,595.9
1979	6,045.0	809.7	1,637.5
1980	7,361.4	996.9	1,872.9
ACRG (%)	14.8 ³	30.0	10.6

¹ Medicare data are for calendar years; Medicaid figures are for fiscal years.

² Includes reimbursements for physicians' services, ambulance services, independent laboratory services, durable medical equipment, and prosthetic devices. Therefore, these data are not directly comparable to Medicaid payments, which cover only physicians' services.

³ ACRG computed for 1967 through 1980 because the 1966 figure is for July through December.

ACRG: Annual compound rate of growth.

"—" Data not available.

NA Not applicable.

SOURCES: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA; Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. Medicaid figures for FY 1980 are from *Annual Medicaid Statistics*, unpublished.

FIGURE 2.8
Medicare Reimbursements and Medicaid Payments
for Short-Stay Hospital Services, 1967-1980

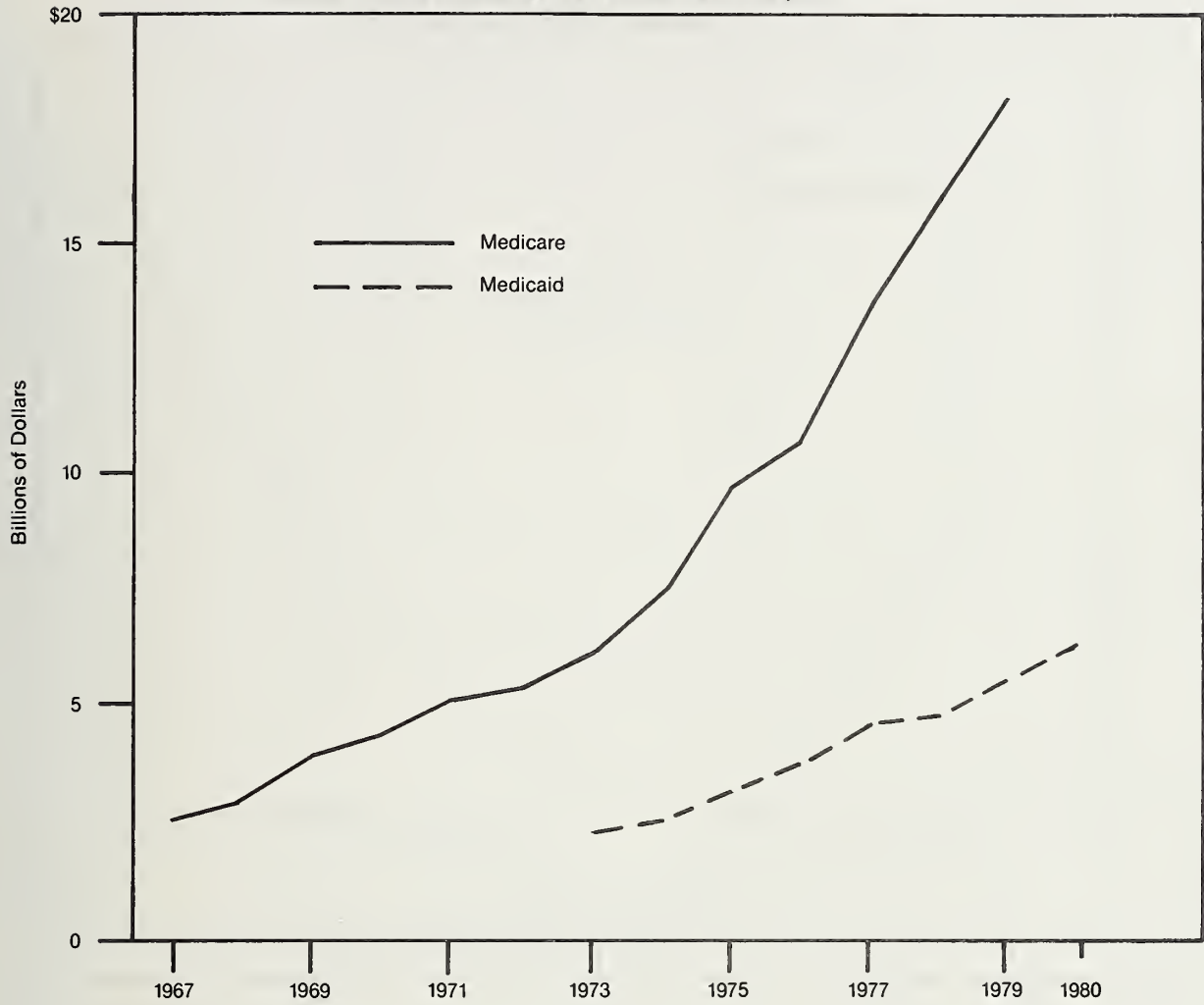


FIGURE 2.9
Medicare Reimbursements for Physicians' and Other
Medical Services, and Medicaid Payments for
Physicians' Services, 1966-1980

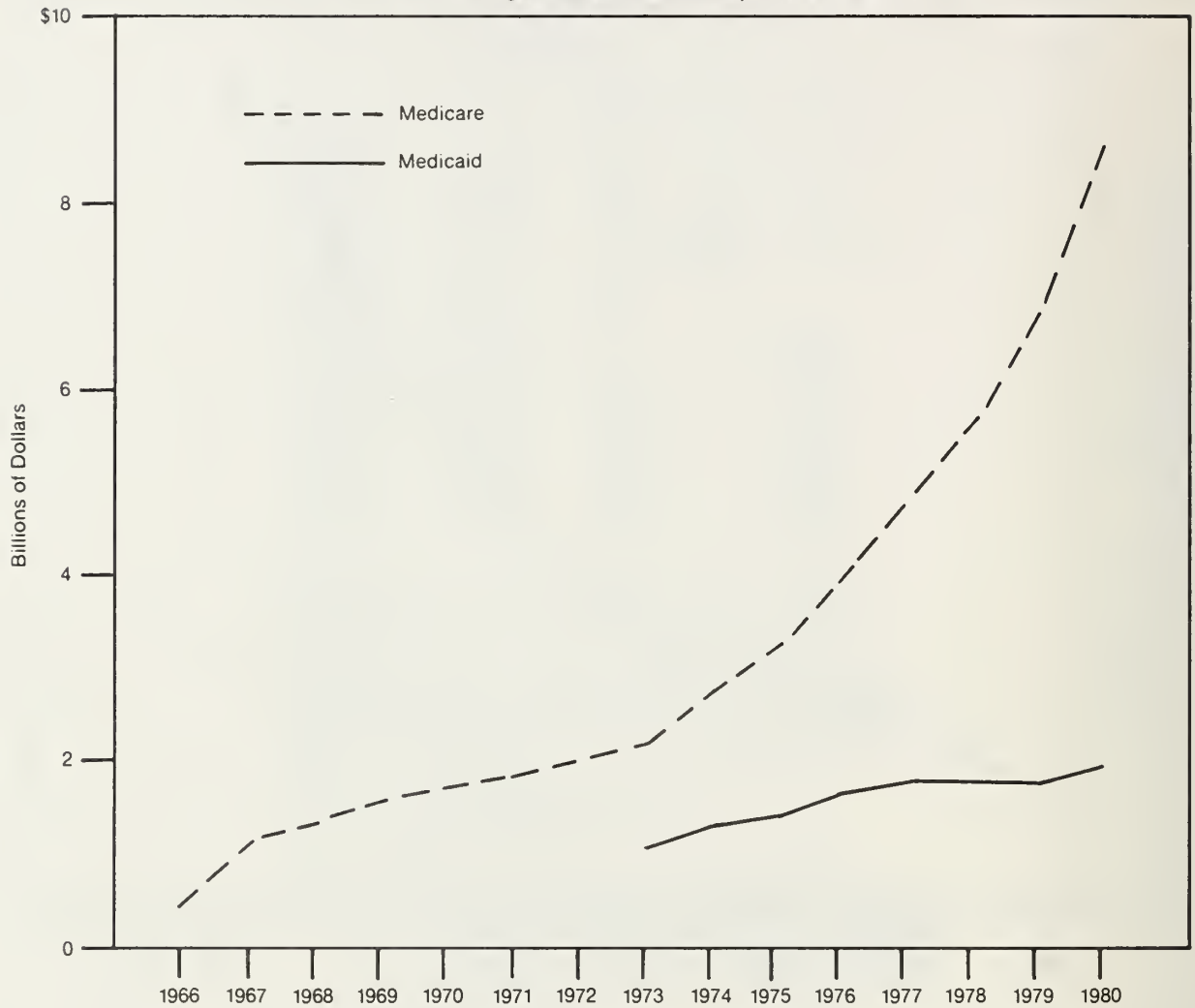


FIGURE 2.10
Medicare Reimbursements for Selected Services,
1966-1980

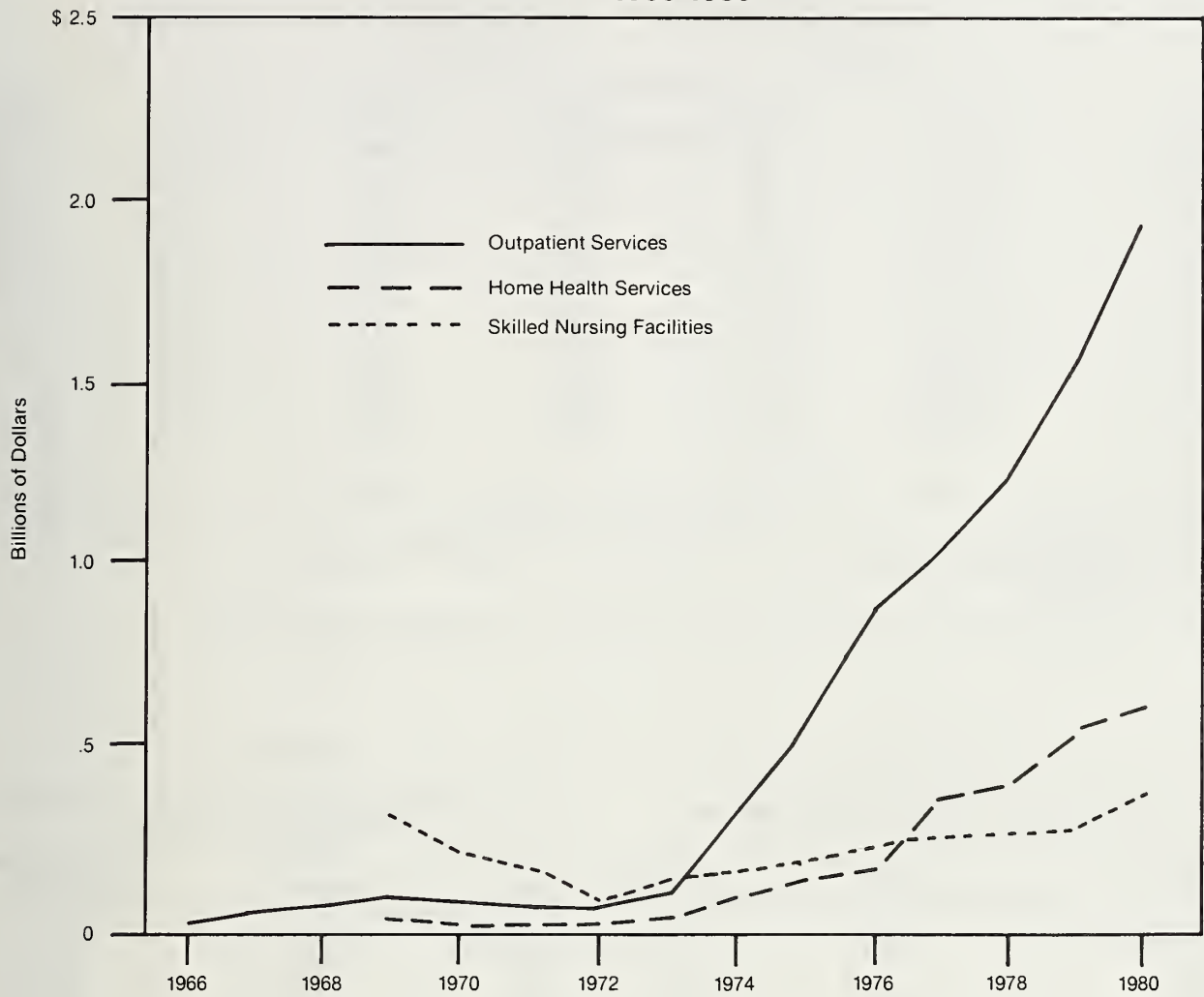


TABLE 2.12

Use of Skilled Nursing Facilities under Medicare, Charges, and Reimbursements, by Type of Enrollee, 1969-1980

Year	Covered Days of Care (thousands)		Covered Charges (millions)		Reimbursements (millions)	
	Aged	Disabled	Aged	Disabled	Aged	Disabled
1969	17,572.5	NA	\$432.2	NA	\$335.0	NA
1970	10,697.1	NA	295.1	NA	225.6	NA
1971	7,481.1	NA	229.9	NA	178.7	NA
1972	6,628.0	NA	212.1	NA	164.1	NA
1973	8,523.0	106.4	278.1	\$ 4.0	209.8	\$ 2.9
1974	8,687.9	277.0	322.9	11.8	237.6	8.3
1975	8,584.7	289.1	405.5	14.8	251.5	9.6
1976	9,406.7	316.6	448.7	17.6	293.5	11.2
1977	9,296.4	334.8	478.5	20.0	301.0	12.3
1978	8,643.0	315.0	493.9	20.7	304.0	12.5
1979	8,047.5	309.8	516.9	22.5	312.4	13.3
1980 ¹	7,975.8	298.5	569.6	24.0	337.1	13.5
ACRG (%)	-6.9	1.3 ²	2.5	12.6 ²	0.1	8.4 ²

¹ Preliminary estimates.² ACRG computed for 1974 through 1980 because the 1973 figure covers July through December 1973.

ACRG: Annual compound rate of growth.

NA Not applicable.

SOURCE: Bureau of Data Management and Strategy, HCFA, unpublished Current Utilization Table AA8, SNF Bills.

TABLE 2.13

Reimbursements for Outpatient Services Under Medicare, by Type of Enrollee, 1966-1980 (millions)

Year	Aged	Disabled
1966 (6 months)	\$ 38.3	NA
1967	56.7	NA
1968	78.6	NA
1969	103.1	NA
1970	—	NA
1971	124.5	NA
1972	148.2	NA
1973	179.2	—
1974	252.5	\$145.3
1975	374.4	221.2
1976	516.2	308.8
1977	649.0	391.7
1978	798.0	480.4
1979	997.1	582.9
1980	1,260.7	700.7
ACRG (%)	26.9 ¹	30.0

¹ ACRG computed for 1967 through 1980 because the 1966 figure covers July through December 1966.

ACRG: Annual compound rate of growth.

NA Not applicable.

"—" Data not available.

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 2.14

Use of and Reimbursements for Home Health Services Under Medicare, 1969-1980

Year	Visits (thousands)	Reimbursements (millions)
1969	8,500	\$ 78.1
1970	6,000	61.5
1971	4,800	56.8
1972	5,200	65.9
1973	6,400	92.9
1974	8,200	144.3
1975	10,900	217.0
1976	13,500	294.6
1977	15,600	366.5
1978	17,100	426.9
1979	19,200	518.2
1980	22,400	662.1
ACRG (%)	9.2	21.4

ACRG: Annual compound rate of growth.

SOURCE: Charles Helbing, "Medicare: Use of Home Health Services, 1979," *Health Care Financing Notes* (November 1980), HCFA Pub. No. 03126, and Home Health Agency Control Table, 1980, unpublished.

FIGURE 2.11
Medicaid Payments for Nursing Facility Services, Fiscal Years 1973-1980

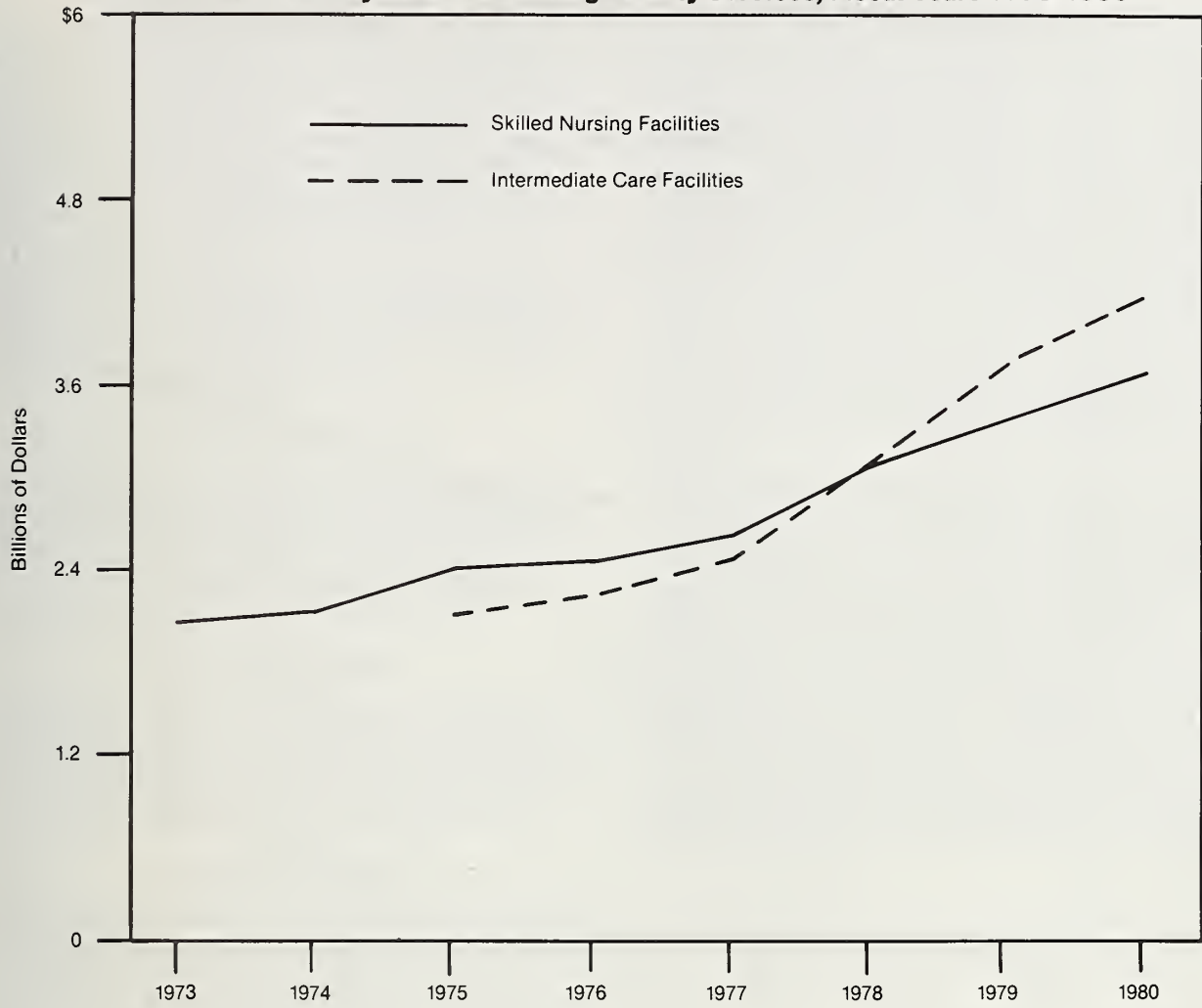
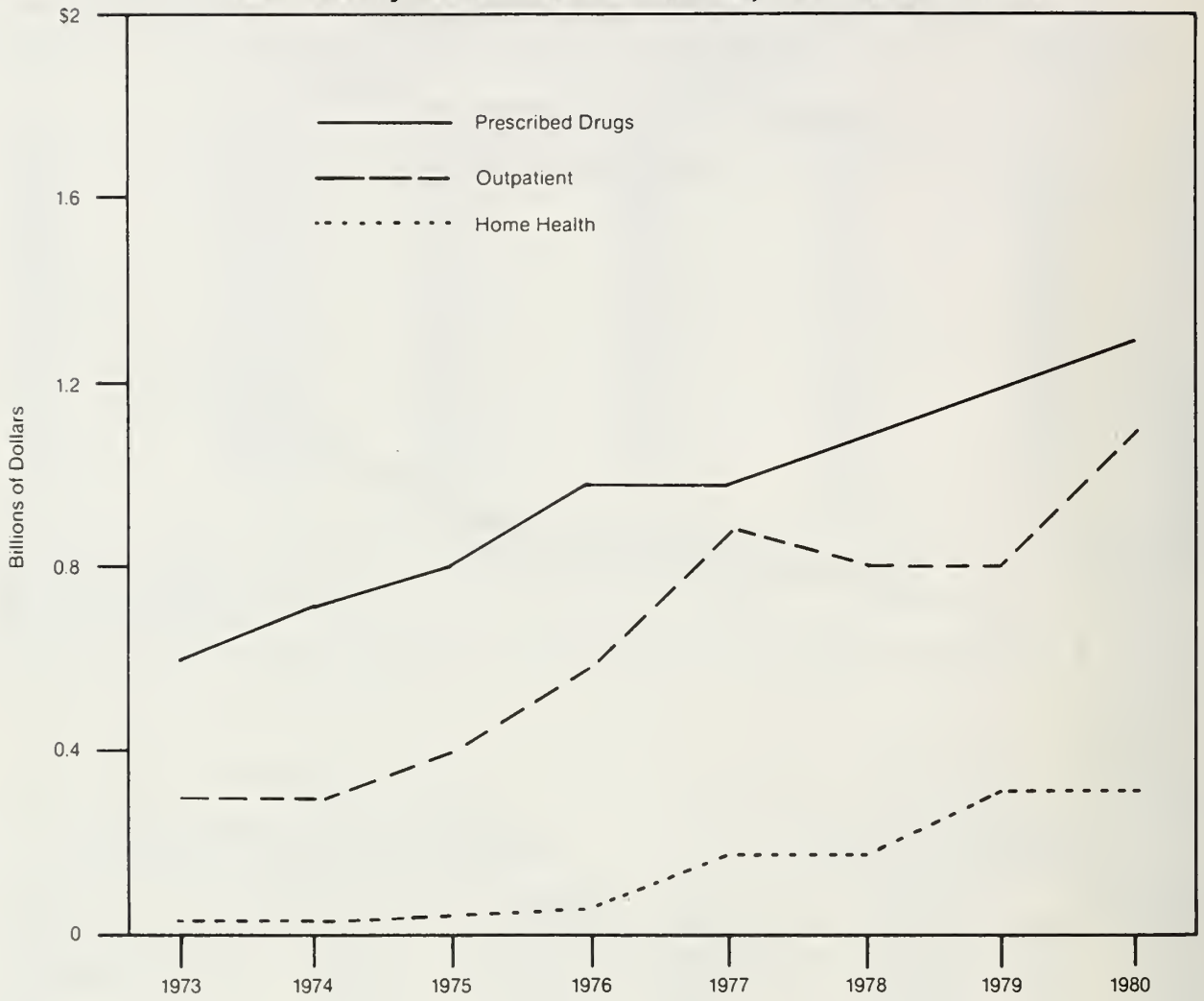


FIGURE 2.12
Medicaid Payments for Selected Services, Fiscal Years 1973-1980



1. Skilled Nursing Facilities and Intermediate Care Facilities

Table 2.15 reports data on the use of and payments to SNF's under Medicaid. Between 1973 and 1980, the number of discharges from SNF's and total days of care declined at annual rates of 1.4 and .7 percent, respectively. Neither measure of use has exhibited a steady trend over this period. Both declined between 1973 and 1976, but have fluctuated since then. In spite of these fluctuations in use, payments grew steadily at an annual rate of 9.5 percent.

Data on trends in the use of and payments to ICF's between 1975 and 1980 are presented in Table 2.16. Payments grew at an annual rate of 17.7 percent. The number of recipients and days of care grew more slowly, 3.9 and 4.3 percent per year, respectively.

2. Hospital Outpatient Services

Table 2.17 reports data for hospital outpatient services under Medicaid between 1973 and 1979. The number of recipients grew annually from 1973 through 1977, declined between 1977 and 1979, and then rose again in 1980. Payments increased almost three times faster than recipients during the period 1973 to 1980.

3. Home Health Services

As shown in Table 2.18, home health care is one of the fastest growing services covered by Medicaid. Between 1973 and 1980, the number of recipients increased at an average annual rate of 20.0 percent. Payments grew at an even higher rate of 44.4 percent per year.

4. Prescription Drugs

Table 2.19 shows data on the use of and payments for prescription drugs under Medicaid. Both the number of recipients and number of prescriptions grew over the period, with the growth in the number of prescriptions surpassing that of recipients. Prescriptions per recipient grew at a rate of 1.4 percent per year, increasing from 10.5 per recipient in 1973 to 11.6 per recipient in 1980. Payments for prescriptions grew steadily at an annual rate of 11.7 percent.¹⁰

5. Sterilizations

Data were collected on Federally-financed sterilization procedures reported under Title XIX for calendar years 1975 through 1980. These data are obtained from quarterly reports submitted on a routine basis by individual State Medicaid Agencies. Table 2.20 shows the total number of sterilizations reported on an annual basis. The reporting system used to produce these figures was not implemented until July 1, 1975; as a result, the 1975 annual figures do not cover the entire year.

Females accounted for about 95 percent of all sterilizations in each year, with tubal ligation, by far, the most common procedure. Hysterectomies have declined considerably in volume, from 13.3 percent of female sterilizations in 1975 to 2.1 percent in 1978. Almost all male sterilizations are vasectomies.

F. Summary of Program Contrasts

As this chapter demonstrates, program trends in Medicare and Medicaid differ in several important ways. Although total reimbursements grew rapidly in both programs, Medicare program expenditures rose faster both in absolute and percentage terms. Since the inception of the programs, the number of Medicare enrollees has been increasing, while the number of Medicaid recipients has remained relatively constant since 1977. Given the growing size of the aged population and eligibility differences between the two programs, the number of Medicare enrollees can be expected to continue to increase in relation to the number of Medicaid recipients.

This chapter also points out that the Medicare and Medicaid programs provide different mixes of benefits. Medicare reimbursements for acute hospital care services for the aged dominate the program, whereas Medicaid payments are increasingly for long-term care services.

The implications of the growth in expenditures are very different for the two programs. Although both programs represent a significant share of public spending on personal health care in this country, the Medicaid program also has a major impact on State and local budgets. Indeed, Medicaid expenditures represent both the largest and fastest growing component of many State budgets. In light of these trends, controlling Medicaid expenditures has become a major priority in many States. Evolving Federal law and State responses suggest that there may be significant changes in the Medicaid program in coming years. These changes can be expected to affect the Medicare program as well, by providing pressures to substitute Medicare covered services for Medicaid services.

¹⁰Medicare does not cover the costs of drugs outside of an inpatient setting.

TABLE 2.15
Use of and Payments to Skilled Nursing Facilities
Under Medicaid, 1973-1980¹

Year	Discharges (thousands)	Days of Care (thousands)	Payments (millions)
1973	677.9 ²	123,082.7 ²	\$1,958.9 ²
1974	646.0 ³	121,006.0 ³	2,001.9 ³
1975	621.4	118,775.0	2,466.2
1976	586.2	108,774.5	2,488.4
1977	605.6	116,760.7	2,686.9
1978	615.3	115,738.9	3,093.6
1979	599.1	115,557.1	3,368.8
1980	612.4	117,431.2	3,706.5
ACRG (%)	-1.4	-0.7	9.5

¹ Figures may not match data on Table 4.13 because missing States have been estimated for this Table.

² Michigan ICF's included with SNFs.

³ West Virginia, Missouri, and North Carolina ICF's included with SNF's.

ACRG: Annual compound rate of growth.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1980. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

TABLE 2.16
Use of and Payments to Intermediate Care Facilities
Under Medicaid,¹ 1975-1980

Year	Recipients (thousands)	Days of Care (thousands)	Payments (millions)
1975	652.2	157,483.7	\$1,866.7
1976	679.6	166,805.9	2,189.1
1977	735.7	172,088.1	2,647.4
1978	729.6	167,967.8	3,120.8
1979	760.0	187,375.9	3,770.9
1980	791.3	194,216.0	4,221.3
ACRG (%)	3.9	4.3	17.7

¹ Data for all intermediate care facilities other than those for the mentally retarded. Data for 1973 and 1974 are not included in this Table since ICF data were not reported as a separate category in those years. Figures may not match data on Table 4.13 because missing States has been estimated for this Table.

ACRG: Annual compound rate of growth.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1980. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

TABLE 2.17

Use of and Payments for Hospital Outpatient Services under Medicaid, 1973-1980

Year	Recipients (thousands)	Payments (millions)
1973	5,295.4	\$ 267.6
1974	5,544.5	322.0
1975	6,157.8	377.2
1976	6,980.7	556.3
1977	8,332.7	885.2
1978	8,287.9	831.6
1979	7,505.7	836.7
1980	9,577.5	1,102.1
ACRG (%)	8.8	22.4

ACRG: Annual compound rate of growth.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

TABLE 2.18

Use of and Payments for Home Health Services under Medicaid, 1973-1980

Year	Recipients (thousands)	Payments (millions)
1973	109.9	\$ 25.4
1974	134.7	31.1
1975	202.4	70.3
1976	227.2	134.3
1977	363.1	180.0
1978	358.2	209.8
1979	358.4	263.6
1980	393.6	331.8
ACRG (%)	20.0	44.4

ACRG: Annual compound rate of growth.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

TABLE 2.19

Use of and Payments for Prescription Drugs under Medicaid, 1973-1980

Year	Number of Recipients (thousands)	Number of Prescriptions (thousands)	Prescriptions Per Recipient	Payments for Prescriptions (millions)
1973	12,116.2	127,293.4	10.5.	\$ 609.3
1974	13,989.4	143,179.5	10.2	712.6
1975	14,019.9	154,701.1	11.0	832.2
1976	14,336.9	170,287.8	11.9	957.0
1977	15,000.3	173,891.1	11.6	1,027.2
1978	14,736.3	176,991.2	12.0	1,084.1
1979	14,198.7	177,657.2	12.5	1,202.4
1980	13,765.7	159,641.8	11.6	1,321.2
ACRG (%)	1.8	3.3	1.4	11.7

ACRG: Annual compound rate of growth.

SOURCE: Office of Research and Demonstrations, HCFA, *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979. FY 1980 figures are from *Annual Medicaid Statistics*, unpublished.

TABLE 2.20

Number of Sterilizations under Medicaid, by Sex and Type of Procedure, 1975-1980

Year	Total Sterilizations ¹	Sex and Type of Procedure						
		Males			Females			
		Total	Vasectomy	Other	Total	Tubal Ligation	Hysterectomy	Other
1975 ²	33,805	1,773	1,197	565	32,032	26,685	4,259	1,088
1976	67,575	2,709	2,684	25	64,866	57,546	3,652	3,668
1977	63,679	2,781	2,761	20	60,898	57,189	379	3,330
1978	65,775	2,787	2,763	24	62,988	57,979	1,311	3,698
1979	73,746	—	—	—	—	—	—	—
1980	86,597	—	—	—	—	—	—	—

¹ Not all jurisdictions report all sterilizations in every year. Thus, year-to-year fluctuations are partially due to variations in reporting.² Data covers only last 6 months of 1975.

"—" Data not available.

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished data.

III. The Medicare Program: Description and Data

This chapter presents detailed information on the Medicare program. This program for financing health care for the aged was enacted on July 30, 1965, as Title XVIII of the Social Security Act. Benefits began on July 1, 1966. The Medicare program (Health Insurance for the Aged) was substantially expanded by the 1972 amendments to the Social Security Act (Public Law 92-603). These amendments (effective July 1, 1973) extended Medicare coverage to disabled beneficiaries of the social security and railroad retirement programs and to persons requiring dialysis or a kidney transplant for end-stage renal disease. The official name of the Medicare program was then changed to Health Insurance for the Aged and Disabled. This chapter describes major changes in the Medicare law through the "Omnibus Budget Reconciliation Act of 1981" (Public Law 97-35), which became law on August 13, 1981.

The Secretary of the Department of Health and Human Services (DHHS) has overall responsibility for the Medicare program. Within DHHS, the Health Care Financing Administration (HCFA) administers Medicare. Medicare consists of two separate but complementary insurance programs: Hospital insurance (HI) and supplementary medical insurance (SMI). HI covers inpatient hospital and skilled nursing facility services, and SMI covers physicians' and related services for eligibles who voluntarily pay premiums and those whose premiums are paid for them.

The next four sections describe eligibility standards, benefits, financing, and administration of HI and SMI. Data are presented for HI and SMI experience on these subjects. Analysis of the distribution of benefits is presented according to the following formula:

$$\frac{\text{Persons Served}}{\text{Enrollees}} \times \frac{\text{Reimbursements}}{\text{Persons Served}} = \frac{\text{Reimbursements}}{\text{Enrollees}}$$

Where

- Persons Served are persons who exceeded deductibles (HI or SMI) and were reimbursed by Medicare for services received;
- Persons Served/Enrollees is the proportion of enrollees who exceeded deductibles and were reimbursed for covered services;
- Reimbursements/Persons Served is the average Medicare reimbursement for persons who received Medicare reimbursements;
- Reimbursement/Enrollees is the average Medicare reimbursement for a population group.

The final sections of this chapter discuss the Medicare program's arrangements with Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's), and describe the Medicare program's statistical systems.

A. Eligibility

All persons 65 years of age and over who are entitled to monthly social security cash benefits or payments from the railroad retirement system are eligible for benefits under the HI program. Effective July 1, 1973, dis-

abled persons entitled for not less than 24 consecutive months to cash benefits under the social security or railroad retirement programs are eligible for benefits under the HI program. The Social Security Amendments of 1980 (Public Law 96-265) removed the consecutive months requirement, effective December 1, 1980. A person must be disabled for 5 calendar months before disability benefits can begin. Thus, Medicare coverage begins the 30th month after the first full calendar month of disability.

HI protection also extends to persons who have end-stage renal disease (ESRD) and who require renal dialysis or a kidney transplant, if they are currently insured or entitled to monthly social security benefits, or if they are the spouses or dependent children of such insured persons. Eligibility for coverage begins with the third month after a course in renal dialysis begins, or before this qualifying dialysis period for ESRD enrollees who receive kidney transplants without starting or receiving dialysis in preparation for transplantation. Eligibility ends with the 36th month after a person receives a kidney transplant, or after dialysis treatment has been terminated.

The 1972 Amendments, effective July 1973, permitted most persons 65 years of age and over who were ineligible for HI coverage to enroll voluntarily by paying a monthly premium. This "premium-HI" was set at \$113 a month beginning July 1982 and represents the full premium cost of HI. To obtain "premium-HI," the law required the enrollee to also obtain SMI coverage. The Omnibus Budget Reconciliation Acts of 1980 and 1981 made the premium-HI enrollment procedure the same as the SMI procedure. As a result, effective April 1981, aged enrollees may terminate and reenroll an unlimited number of times. However, they may enroll or reenroll only during January through March of each year.

Persons entitled to benefits under the HI program and most other persons 65 years of age and over may voluntarily enroll in SMI. Only the aged can enroll for SMI without being eligible for HI; disabled persons may not. The Omnibus Budget Reconciliation Act of 1981, effective October 1, 1981, repealed SMI continuous open enrollment. It reinstated the general enrollment period which occurs January through March of each year. Coverage becomes effective July 1. Persons may terminate SMI enrollment by not paying premiums, and may reenroll by resuming premium payments.¹¹

Under the State buy-in system, a State government may enroll and pay SMI premiums for eligible aged and disabled individuals who are also covered by the Medicaid program.

Table 3.1 shows data on the total number of aged and disabled persons enrolled in Medicare (HI and/or SMI) in 1979 and 1980. Total Medicare enrollees numbered 28.5 million in 1980, 90 percent of whom were aged. More than 98 percent of them were enrolled for both HI and SMI or only for HI. The remainder, 411,000 aged who were ineligible for HI, were enrolled for only SMI.

Ninety-two percent of disabled HI enrollees were also enrolled for SMI. Nearly 67,000 aged and disabled enrollees had end-stage renal disease. Of these, 43 percent were deemed disabled solely because they were ESRD patients; 30 percent were entitled to disability cash benefits; and 27 percent were 65 years of age and over.

¹¹To do so, an individual must pay a surcharge of 10 percent for every 12 months that he or she could have been enrolled.

TABLE 3.1

Number of Aged and Disabled Medicare Enrollees by Type of Coverage,
as of July 1, 1979 and July 1, 1980

Type of Enrollee	Hospital Insurance and/or Supplementary Medical Insurance (thousands)		Hospital Insurance (thousands)		Supplementary Medical Insurance (thousands)	
	July 1, 1979	July 1, 1980	July 1, 1979	July 1, 1980	July 1, 1979	July 1, 1980
Total	27,858.7	28,478.2	27,459.2	28,066.9	26,757.3	27,399.7
Aged ¹	24,948.0	25,515.1	24,548.4	25,103.7	24,098.5	24,680.4
Disabled ²	2,910.8	2,963.2	2,910.8	2,963.2	2,658.8	2,719.2
ESRD—only ³	23.6	28.3	23.6	28.3	22.4	27.0

¹ All enrollees 65 years of age and over, including enrollees with end-stage renal disease (ESRD). Aged enrollees with ESRD covered by HI and/or SMI numbered 17,478 on July 1, 1979 and 18,327 on July 1, 1980.

² All enrollees under 65 years of age, including enrollees with ESRD. Enrollees with ESRD covered by HI and/or SMI and entitled to cash benefits for disability numbered 19,532 on July 1, 1979 and 20,080 on July 1, 1980.

³ Persons eligible solely because of ESRD.

SOURCE: Elvira Fussel, "Persons Enrolled for Medicare, 1980," *Health Care Financing Notes*, September 1983, Pub. No. 03160.

For all Medicare-eligibles, the number of enrollees was highest in the South and lowest in the West (Table 3.2). Tables 3.3 and 3.4 present detailed data on the distribution of HI and SMI benefits for aged and disabled enrollees respectively. Much larger proportions of aged and disabled enrollees received SMI benefits than HI benefits. For both groups, average reimbursements per person served were far higher for HI than for SMI.

The proportions of both aged and disabled enrollees receiving benefits (persons served per thousand enrollees) were higher for older age groups for both HI and SMI.

B. Benefits

1. Overview

The HI program covers inpatient hospital care and post-hospital care in skilled nursing facilities (SNF's). The program also covers home health agency (HHA) services for persons confined to the home who need skilled nursing care or physical or speech therapy.¹² To be covered, services must be provided by institutions and organizations that have been certified as qualified providers and that have agreements to participate in the program. Exceptions to this rule are made for emergency services.

¹² Prior to the Omnibus Reconciliation Act of 1980, the HI program covered home health visits only if they followed a hospital stay. Home health visits that did not follow a hospital stay were covered by the SMI program. Coverage under HI was limited to 100 visits per benefit period and under SMI to 100 visits in a calendar year. The 1980 law, effective July 1, 1981, eliminated the HI requirement of prior hospitalization and the limits on visits. Under the new law, all home health visits are covered by the HI program unless a beneficiary has SMI coverage only. In such cases, home health visits will be covered by the SMI program.

The SMI program covers a variety of medical services and supplies furnished by physicians or other health care professionals in connection with physicians' services, and for outpatient and home health services.

Table 3.5 presents counts of the number of institutional providers participating in Medicare in 1981. Most of the nation's hospitals participated in Medicare, and they were the largest class of participating providers (6,736 hospitals with 1.1 million beds). Hospitals also received the largest share of Medicare's reimbursements. As shown in Table 3.6, almost all HI reimbursements and 68 percent of total Medicare reimbursements went for hospital inpatient services in fiscal 1981. SMI reimbursements accounted for less than 30 percent of total reimbursements, 77 percent of which was for physicians' services. Table 3.6 also reveals that the distribution of reimbursements differed for aged and disabled enrollees. Disabled enrollees received a smaller proportion of HI reimbursements and a larger proportion of SMI reimbursements than aged enrollees.

Tables 3.7 and 3.8 present information on the distribution of specific benefits for aged and disabled enrollees. In 1980, the proportion of aged enrollees receiving all listed benefits was successively higher for each older age group. Among the aged, the largest proportion, by far, received physicians' services, followed by outpatient and inpatient hospital services. Very small proportions of aged enrollees received SNF or HHA benefits. The proportion of aged persons of races other than white receiving outpatient and home health services was greater than that of white persons. For other services, larger proportions of aged white persons received Medicare benefits. Reimbursements per person served were higher for aged persons of races other than white than for aged white persons for all except physicians' services (Ruther and Dobson, 1981). With the exception of inpatient hospital benefits, a larger proportion of aged women than aged men received benefits. For all aged enrollees, reimbursement per person served was highest

TABLE 3.2

**Medicare Enrollees by Type of Coverage, Census Region,
and Census Division, July 1, 1980¹**

Census Region and Division	Hospital Insurance and/or Supplementary Medical Insurance			Hospital Insurance			Supplementary Medical Insurance		
	Total	Aged	Disabled ²	Total	Aged	Disabled ²	Total	Aged	Disabled ²
All Areas	28,478,245	25,515,070	2,963,175	28,066,894	25,103,738	2,963,156	27,399,658	24,680,432	2,719,226
United States ³	27,889,898	25,027,379	2,862,519	27,479,707	24,617,207	2,862,500	27,143,002	24,467,789	2,675,213
Northeast	6,635,624	6,001,340	634,284	6,549,633	5,915,353	634,280	6,473,875	5,884,366	589,509
New England	1,646,813	1,505,828	140,985	1,628,241	1,487,258	140,983	1,605,827	1,477,103	128,724
Middle Atlantic	4,988,811	4,495,512	493,299	4,921,392	4,428,095	493,297	4,868,048	4,407,263	460,785
North Central	7,314,626	6,648,146	666,480	7,242,256	6,575,780	666,476	7,139,636	6,519,828	619,808
East North Central	4,948,189	4,461,952	486,237	4,895,789	4,409,555	486,234	4,826,249	4,374,177	452,072
West North Central	2,366,437	2,186,194	180,243	2,346,467	2,166,225	180,242	2,313,387	2,145,651	167,736
South	9,234,376	8,155,350	1,079,026	9,052,871	7,973,853	1,079,018	8,962,279	7,948,520	1,013,759
South Atlantic	4,724,367	4,179,117	545,250	4,634,211	4,088,966	545,245	4,587,863	4,075,821	512,042
East South Central	1,859,104	1,613,165	245,939	1,816,016	1,570,078	245,938	1,808,911	1,575,498	233,413
West South Central	2,650,905	2,363,068	287,837	2,602,644	2,314,809	287,835	2,565,505	2,297,201	268,304
West	4,678,855	4,200,270	478,585	4,610,519	4,131,937	478,582	4,543,362	4,094,999	448,363
Mountain	1,155,212	1,043,246	111,966	1,141,971	1,030,006	111,965	1,114,494	1,011,472	103,022
Pacific	3,523,643	3,157,024	366,619	3,468,548	3,101,931	366,617	3,428,868	3,083,527	345,341

¹ Based on data recorded in Health Insurance master file on March 30, 1981.² Includes enrollees under 65 years of age with end-stage renal disease and enrollees with end-stage renal disease only.³ Consists of 50 States, District of Columbia, and residence unknown.SOURCE: Elvira Fussell, "Persons Enrolled for Medicare, 1980," *Health Care Financing Notes*, September 1983, Pub. No. 03160.

TABLE 3.3

Persons Served and Reimbursements for Aged Medicare Enrollees,
by Type of Coverage, Age, Sex, Race, and Census Region, 1980

Age, Sex, Race, and Census Region	Hospital Insurance and/or Supplementary Medical Insurance				Hospital Insurance				Supplementary Medical Insurance			
	Hospital Insurance		Supplementary Medical Insurance		Hospital Insurance		Supplementary Medical Insurance		Hospital Insurance		Supplementary Medical Insurance	
	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	Persons Served Per 1,000 Enrollees
Total	637.7	\$1,791	\$1,142	240.0	\$3,379	\$ 811	652.3	\$545	652.3	\$ 811	\$356	652.3
Age												
65-69	579.2	1,490	863	187.0	3,119	583	593.9	508	593.9	508	302	593.9
70-74	623.5	1,676	1,045	218.9	3,311	725	635.2	547	635.2	547	348	635.2
75-79	672.3	1,919	1,290	264.3	3,499	925	683.8	571	683.8	571	390	683.8
80-84	702.6	2,129	1,496	306.7	3,589	1,101	717.8	573	717.8	573	411	717.8
85 Years & Over	731.1	2,247	1,643	347.6	3,561	1,238	759.8	564	759.8	564	429	759.8
Sex												
Male	607.8	2,013	1,224	253.5	3,419	867	623.3	612	623.3	612	381	623.3
Female	657.9	1,652	1,087	230.8	3,349	773	671.6	504	671.6	504	339	671.6
Race												
White	643.9	1,776	1,144	242.7	3,327	808	656.6	543	656.6	543	357	656.6
All other Races	587.5	1,981	1,164	218.1	3,978	868	616.5	578	616.5	578	356	616.5
Region												
Northeast	685.7	1,811	1,242	225.4	3,875	874	694.0	559	694.0	559	388	694.0
North Central	618.5	1,886	1,167	256.1	3,410	873	624.3	495	624.3	495	309	624.3
South	625.7	1,656	1,036	256.6	2,845	730	635.4	521	635.4	521	331	635.4
West	678.9	1,885	1,280	222.6	3,871	862	686.9	645	686.9	645	443	686.9

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.4

Persons Served and Reimbursements for Disabled Medicare Enrollees, by Type of Coverage,
Age, Sex, Race, and Census Region, 1980

Age, Sex, Race, and Census Region	Hospital Insurance and/or Supplementary Medical Insurance				Hospital Insurance				Supplementary Medical Insurance			
	Supplementary Medical Insurance		Hospital Insurance		Hospital Insurance		Hospital Insurance		Supplementary Medical Insurance		Supplementary Medical Insurance	
	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Person Served	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee
Total	594.1	\$2,544	\$1,511	245.7	\$3,798	\$ 933	633.8	\$ 994	\$630			
Age												
Under 35	490.6	3,071	1,507	187.8	4,454	836	521.7	1,405	733			
35-44	524.8	2,748	1,442	208.0	3,936	819	562.0	1,216	683			
45-54	567.8	2,607	1,480	240.6	3,703	891	612.8	1,060	650			
55-59	598.3	2,455	1,469	252.8	3,702	936	642.2	909	584			
60-64	679.8	2,344	1,594	282.9	3,700	1,047	715.5	820	587			
Sex												
Male	538.2	2,497	1,344	227.6	3,703	843	579.2	956	554			
Female	689.7	2,607	1,798	276.7	3,932	1,088	724.0	1,045	757			
Race												
White	593.0	2,446	1,451	247.7	3,703	917	634.1	919	582			
All Other Races	584.6	3,039	1,776	230.2	4,310	992	618.1	1,373	848			
Region												
Northeast	643.2	2,558	1,646	235.8	4,230	998	678.6	1,027	697			
North Central	602.1	2,732	1,645	265.9	4,107	1,092	632.9	939	594			
South	568.9	2,352	1,338	262.2	3,133	822	592.6	927	549			
West	670.1	2,700	1,809	232.2	4,548	1,056	704.3	1,142	804			

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.5

Number and Type of Facilities Participating in the Medicare Health Insurance Program and
Percent Change, All Areas, July 1975–July 1981

Type of Facility	1975	1976	1977	1978	1979	1980	1981	Percent Change 1975-81
Facilities								
Hospitals	6,773	6,802	6,806	6,797	6,801	6,777	6,736	-.5
Short-Stay	6,107	6,112	6,131	6,130	6,128	6,104	6,065	-.7
Psychiatric	385	401	400	400	411	408	412	7.0
Other Long-Stay ¹	238	251	239	241	244	265	259	8.8
Skilled Nursing Facilities	3,932	3,928	4,002	4,749	4,963	5,052	5,258	33.7
Home Health Agencies	2,242	2,361	2,420	2,605	2,788	2,924	3,110	38.7
Independent Laboratories	3,048	3,194	3,221	3,281	3,373	3,447	3,484	14.3
Beds								
Hospitals	1,140,395	1,149,122	1,162,990	1,142,248	1,147,498	1,149,997	1,147,324	.6
Short-Stay	901,757	922,601	953,067	965,323	985,070	990,621	997,020	10.6
Psychiatric	198,802	188,288	172,949	145,376	133,106	131,276	123,527	-37.9
Other Long-Stay ¹	33,013	32,479	29,390	27,827	27,069	28,100	26,777	-18.9
Skilled Nursing Facilities	287,479	309,790	349,650	418,246	419,835	436,007	457,692	59.2

¹ Certified tuberculosis hospitals are included with other long-stay hospitals. As of July 1981 only 13 tuberculosis hospitals remained in the Medicare program.

SOURCE: Charles Helbing, "Medicare: Participating Providers and Suppliers of Health Services, 1981," *Health Care Financing Notes*, September 1983, Pub. No. 03161.

TABLE 3.6

Medicare Reimbursements, by Type of Enrollee, Type of Coverage,
and Type of Service, Fiscal Year 1981

Type of Service	All Enrollees		Aged		Disabled	
	Reimbursements (millions)	Percent	Reimbursements (millions)	Percent	Reimbursements (millions)	Percent
Hospital Insurance and/or Supplementary Medical Insurance	\$41,254	100.0	\$35,797	100.0	\$5,457	100.0
Hospital Insurance	28,909	70.1	25,471	71.2	3,438	63.0
Inpatient Hospital	27,837	67.5	24,467	68.3	3,370	61.8
Skilled Nursing Facility	404	1.0	388	1.1	16	.3
Home Health Agency	668	1.6	616	1.7	52	1.0
Supplementary Medical Insurance	12,345	29.9	10,326	28.8	2,019	37.0
Physicians'	9,465	22.9	8,324	23.3	1,141	20.9
Outpatient	2,217	5.4	1,393	3.9	824	15.1
Home Health Agency	271	.7	249	.7	22	.4
Group Practice Plans	247	.6	235	.7	12	.2
Independent Laboratory	145	.4	125	.3	20	.4

SOURCE: Bureau of Data Management and Strategy, Office of Financial and Actuarial Analysis, HCFA, Table A2 and B2, unpublished.

TABLE 3.7

Persons Served and Reimbursements for Aged Medicare Enrollees, by Type of Coverage,
Type of Service, Age, Sex, Race, and Census Region, 1980

	Hospital Insurance				Supplementary Medical Insurance			
	Inpatient Hospital Services		Skilled Nursing Facility Services		Physician and Other Medical Services			
	Persons Served Per 1,000 Enrollees	Reimburse-ments Per Person Served	Reimburse-ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse-ments Per Person Served	Reimburse-ments Per Enrollee	Reimburse-ments Per Enrollee	
Total	237.1	\$3,291	\$ 780	9.9	\$1,336	633.2	\$471	\$298
Age								
65-69	185.6	3,074	571	2.7	1,494	572.0	436	249
70-74	216.8	3,241	703	5.5	1,401	617.0	467	288
75-79	260.8	3,403	888	11.2	1,356	666.8	496	331
80-84	301.7	3,465	1,045	19.9	1,312	700.3	502	352
85 Years & Over	340.7	3,418	1,165	31.2	1,261	741.5	493	366
Sex								
Male	251.0	3,352	841	7.9	1,267	603.2	535	323
Female	227.6	3,245	739	11.2	1,369	653.2	432	282
Race								
White	239.8	3,240	777	10.2	1,315	639.6	473	303
All Other Races	214.7	3,873	832	6.9	1,656	576.2	453	261
Region								
Northeast	221.2	3,784	837	9.0	1,511	667.0	479	319
North Central	253.6	3,331	845	11.0	1,367	605.0	428	259
South	254.0	2,767	703	7.9	1,241	619.7	457	283
West	220.2	3,754	827	14.0	1,242	672.8	550	370

(continued)

TABLE 3.7 (continued)

Persons Served and Reimbursements for Aged Medicare Enrollees by Type of Coverage,
Type of Service, Age, Sex, Race, and Census Region, 1980

Age, Sex, Race, and Census Region	Supplementary Medical Insurance				Hospital Insurance and/or Supplementary Medical Insurance			
	Outpatient Services				Home Health Agency Services			
	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Enrollee
Total	268.6	\$190	\$51	38.3	\$613	\$23		
Age								
65-69	248.8	199	49	18.4	606	11		
70-74	263.5	207	55	29.6	624	18		
75-79	278.4	187	52	46.5	628	29		
80-84	288.8	168	48	65.4	611	40		
85 Years & Over	307.2	157	48	81.1	593	48		
Sex								
Male	260.6	206	54	33.1	604	20		
Female	273.9	180	49	41.8	618	26		
Race								
White	266.3	180	48	37.7	599	23		
All Other Races	297.7	285	85	45.4	733	33		
Region								
Northeast	326.3	190	62	52.0	568	30		
North Central	264.4	171	45	32.0	562	18		
South	229.4	177	41	35.5	672	24		
West	277.0	242	67	35.6	642	23		

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.8

Persons Served and Reimbursements for Disabled Medicare Enrollees, by Type of Coverage,
Type of Service, Age, Sex, Race, and Census Region, 1980

Age, Sex, Race, and Census Region	Hospital Insurance				Supplementary Medical Insurance				
	Inpatient Hospital Services		Skilled Nursing Facility Services		Physician and Other Medical Services		Reimburse-ments Per Enrollee		
	Persons Served Per 1,000 Enrollees	Reimburse-ments Per Person Served	Reimburse-ments Per Enrollee	Persons Served Per 1,000 Enrollees	Reimburse-ments Per Person Served	Persons Served Per 1,000 Enrollees			
Total	243.3	\$3,765	\$ 916	2.9	\$1,571	\$5	599.9	\$611	\$367
Age									
Under 35	186.7	4,439	829	1.0	1,679	2	479.3	668	320
35-44	206.6	3,908	808	1.5	1,652	3	524.3	643	337
45-54	238.7	3,676	877	2.1	1,547	3	579.7	625	362
55-59	250.2	3,666	917	3.1	1,576	5	611.4	605	370
60-64	279.4	3,658	1,022	4.6	1,557	7	684.0	581	397
Sex									
Male	225.3	3,683	830	2.4	1,558	4	543.6	604	328
Female	274.0	3,882	1,064	3.7	1,586	6	693.2	620	430
Race									
White	245.4	3,670	901	2.9	1,526	4	604.9	607	367
All Other Races	227.3	4,283	973	2.4	1,833	4	562.3	637	358
Region									
Northeast	232.3	4,195	974	2.6	1,769	5	630.4	608	383
North Central	263.7	4,075	1,075	3.8	1,635	6	600.0	581	349
South	260.2	3,104	808	2.2	1,406	3	563.8	584	330
West	230.2	4,508	1,038	4.0	1,536	6	675.0	708	478

(continued)

TABLE 3.8 (continued)

Persons Served and Reimbursements for Disabled Medicare Enrollees by Type of Coverage,
Type of Service, Age, Sex, Race, and Census Region, 1980

Age, Sex, Race, and Census Region	Supplementary Medical Insurance				Hospital Insurance and/or Supplementary Medical Insurance			
	Outpatient Services				Home Health Agency Services			
	Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee		Persons Served Per 1,000 Enrollees	Reimburse- ments Per Person Served	Reimburse- ments Per Enrollee	
Total	334.4	\$ 771	\$258		25.8	\$696	\$18	
Age								
Under 35	323.6	1,262	408		12.6	769	10	
35-44	331.0	1,028	340		17.7	777	14	
45-54	337.4	836	282		21.5	718	15	
55-59	329.5	631	208		27.8	690	19	
60-64	341.3	535	183		36.1	662	24	
Sex								
Male	301.8	732	221		19.9	659	13	
Female	388.3	820	318		36.0	731	26	
Race								
White	324.6	646	210		24.9	696	17	
All Other Races	379.0	1,277	484		29.5	698	21	
Region								
Northeast	391.2	784	307		36.7	695	26	
North Central	335.2	717	240		24.6	644	16	
South	289.9	740	215		22.2	711	16	
West	383.0	839	321		24.1	708	17	

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

for inpatient hospital services (\$3,291), followed by skilled nursing facility services (\$1,336), and home health agency services (\$613). Reimbursements per person served for physicians' and outpatient services were \$471 and \$190, respectively.

For each service, the amount reimbursed per person served was higher for the disabled than for the aged. Outpatient reimbursements per disabled person served were much higher than reimbursements for the aged because of the higher proportion of ESRD patients among the disabled.

Among disabled persons served, larger proportions of persons other than white received home health and outpatient benefits than did white persons. Reimbursements per person served were higher for persons of races other than white for all services except home health which were about equal. Larger proportions of disabled women than disabled men received all types of benefits. Reimbursements per person served were also consistently higher for disabled women than for disabled men.

2. Benefits Under HI

The law governing the HI program limits coverage to a "benefit period" (or "spell of illness"). A benefit period begins with an enrollee's first day of hospitalization and ends when the enrollee has not been a bed patient in a hospital or skilled nursing facility for at least 60 consecutive days. Although there is no limit to the number of benefit periods that an enrollee may have, there are limits on the number of days covered.

HI covers services in a participating hospital up to 90 days in a benefit period. After an initial deductible (applicable to each benefit period), the patient is entitled to 60 days of hospitalization with no additional cost sharing. The Secretary of DHHS is required each year to determine the deductible amount, using a formula specified by law. The formula is based on the average *per diem* rate for inpatient services during the preceding calendar year. Reflecting increases in hospital costs, the deductible has risen from \$40 in 1966 to \$260 in 1982. From the 61st through the 90th day in the benefit period, the patient is responsible for coinsurance (\$65 per day in 1982) equal to one-fourth of the deductible.

Each HI enrollee also has a "lifetime reserve" of 60 additional hospital days which can be used at the enrollee's option when the 90 days covered in a benefit period have been exhausted. Lifetime reserve days require a coinsurance equal to one-half the deductible (\$130 for each lifetime reserve day in 1982).

The HI program also pays non-participating hospitals for emergency services. Under these provisions, the hospital may bill the program annually for all emergency services rendered. If this arrangement is unacceptable to the provider, the patient pays for services received and submits a claim for reimbursement. These reimbursements are made according to a specified level and subject to a deductible and coinsurance.

Covered hospital services under HI include room and board in semi-private accommodations containing from two to four beds, nursing services (except for private duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients.¹³ The

HI program covers only the services of interns and resident physicians in approved teaching programs. Other physicians' services, including hospital-based specialists, such as, radiologists, anesthesiologists, and pathologists are covered under SMI. Hospital benefits also include reimbursement for inpatient services provided by tuberculosis hospitals and psychiatric hospitals. There is a 190-day lifetime limit for psychiatric hospitals.

The HI program pays hospitals the "reasonable costs" of providing services to Medicare beneficiaries. Reasonable costs are determined after services have been delivered and are based on program regulations. The Medicare law and regulations specify the kinds of hospital costs allowed. For example, Medicare does not cover private duty nursing or costs unrelated to patient care. Once a hospital's total allowable costs are determined, Medicare apportions the costs between Medicare patients and other patients. Medicare then pays allowable costs based on services received by Medicare patients.

The Social Security Amendments of 1983, Public Law 98-21, effective October 1, 1983, established prospective payments for Medicare inpatient hospital services which drastically changed the way hospitals will be paid. This legislation reforms the retrospective, cost-based reimbursement system for inpatient care under Medicare for the "reasonable costs" incurred during the preceding year. The new prospective payment system establishes one price for each of 467 Diagnosis Related Groups. These prices are established in advance for the coming year; hospitals are paid these prices regardless of the costs they actually incur. It is hoped that the prospective payment system will provide incentives for hospitals to control costs.

Tables 3.9, 3.10, and 3.11 report data on the use of and reimbursements for inpatient hospital services. In 1979, there were 9.8 million Medicare inpatient hospital discharges (Table 3.9). These discharges resulted in reimbursements of \$18.4 billion for 102 million covered days of care. Short-stay hospital care accounted for nearly 99 percent of all discharges and reimbursements, and more than 97 percent of covered days of care. Aged enrollees, who represent 89 percent of all HI enrollees, used 88 percent of all covered days of care. Discharges per 1,000 enrollees, covered days of care per 1,000 enrollees, and average reimbursement per enrollee were lower for the aged than the disabled.

Tables 3.10 and 3.11 present data on the use of short-stay hospitals for aged and disabled enrollees, respectively. For both these groups, discharges per 1,000 enrollees and covered days of care per 1,000 were higher for older age groups. Among the aged, the discharge rate of men exceeded that of women. The opposite was true for disabled enrollees. The discharge rate of both aged and disabled white persons exceeded that of persons of other races. Aged and disabled persons of races other than white, however, had longer average lengths of stay and higher reimbursements per discharge and per covered days of care than did white persons. By region, aged enrollees in the South had the highest discharge rate but the lowest reimbursements per discharge and per covered day of care. For both aged and disabled enrollees, the Northeast had the lowest discharge rate and the highest reimbursements per discharge. The West had the highest reimbursements per covered day

¹³Private accommodations are covered if medically necessary; otherwise, the patient must pay a special charge to the hospital.

TABLE 3.9

Use of Inpatient Hospitals by Medicare Enrollees, and Reimbursements, by Type of Enrollee and Type of Hospital, 1979

Type of Hospital	Discharges		Covered Days of Care			Reimbursements			
	Number (thousands)	Per 1,000 Enrollees	Number (thousands)	Per Discharge	Per 1,000 Enrollees	Total Amount (millions)	Per Discharge	Per Covered Day of Care	Per Enrollee
All Enrollees									
Total Inpatient	9,753.2	355.2	101,720.5	10.4	3,704	\$18,428.0	\$1,889	\$181	\$671.11
Short-Stay	9,643.9	351.2	99,147.9	10.3	3,611	18,173.9	1,884	183	661.86
Long-Stay ¹	109.3	4.0	2,572.6	23.5	94	254.1	2,326	99	9.25
Psychiatric	67.6	2.5	1,600.0	23.7	58	122.9	1,818	77	4.48
All Other	41.6	1.5	972.7	23.4	35	131.2	3,151	135	4.78
Aged Enrollees									
Total Inpatient	8,547.6	348.2	89,542.5	10.5	3,648	16,189.5	1,894	181	659.50
Short-Stay	8,483.3	345.6	87,984.8	10.4	3,584	16,021.0	1,889	182	652.64
Long-Stay ¹	64.3	2.6	1,557.7	24.2	63	168.5	2,620	108	6.86
Psychiatric	30.1	1.2	747.6	24.8	30	60.8	2,018	81	2.48
All Other	34.2	1.4	810.1	23.7	33	107.7	3,149	133	4.39
Disabled Enrollees									
Total Inpatient	1,205.5	414.1	12,178.0	10.1	4,183	2,238.5	1,857	184	768.98
Short-Stay	1,160.6	398.7	11,163.1	9.6	3,835	2,152.9	1,855	193	739.57
Long-Stay ¹	44.9	15.4	1,014.9	22.6	349	85.6	1,905	84	29.41
Psychiatric	37.5	12.9	852.4	22.7	293	62.2	1,657	73	21.37
All other	7.4	2.5	162.5	21.9	56	23.4	3,158	144	8.04

¹ Excludes discharges with zero covered days of care.

SOURCE: Medpar: Inpatient Hospital Stay Record File, unpublished data.

TABLE 3.10

Use of Short-Stay Hospitals by Aged Medicare Enrollees, by Age, Sex, Race, and Census Region, 1979

Age, Sex, Race, and Census Region	Aged Hospital Insurance Enrollees (thousands)	Discharges		Covered Days of Care			Reimbursements			
		Number (thousands)	Per 1,000 Enrollees	Number (thousands)	Per Discharge	Per 1,000 Enrollees	Total Amount (millions)	Per Discharge	Per Covered Day of Care	Per Enrollee
Total	24,548	8,483	346	87,984	10.4	3,584	\$16,021	\$1,889	\$182	\$653
Age										
65-66	3,450	896	260	8,423	9.4	2,441	1,593	1,778	189	462
67-68	3,186	866	272	8,274	9.6	2,597	1,556	1,796	188	488
69-70	2,931	858	293	8,385	9.8	2,861	1,564	1,822	187	534
71-72	2,683	844	315	8,435	10.0	3,144	1,565	1,854	186	583
73-74	2,332	804	345	8,272	10.3	3,547	1,523	1,894	184	653
75-79	4,650	1,788	385	18,925	10.6	4,070	3,429	1,918	181	737
80-84	3,013	1,329	441	14,735	11.1	4,890	2,618	1,969	178	869
85 & Over	2,303	1,097	476	12,536	11.4	5,443	2,173	1,981	173	944
Sex										
Male	9,945	3,725	375	37,427	10.1	3,763	7,016	1,884	187	705
Female	14,604	4,759	326	50,557	10.6	3,462	9,005	1,892	178	617
Race										
White	21,770	7,637	351	78,321	10.3	3,598	14,206	1,860	181	653
All Other Races	2,100	633	301	7,421	11.7	3,534	1,410	2,227	190	671
Region										
Northeast	5,822	1,796	308	22,265	12.4	3,824	4,080	2,272	183	701
North Central	6,462	2,386	369	25,354	10.6	3,924	4,589	1,923	181	710
South	7,761	2,957	381	28,671	9.7	3,694	4,568	1,545	159	589
West	4,007	1,287	321	11,104	8.6	2,771	2,733	2,123	246	682

SOURCE: Medpar: Inpatient Hospital Stay Record File, unpublished data.

TABLE 3.11

Use of Short-Stay Hospitals by Disabled Medicare Enrollees, by Age, Sex, Race, and Census Region, 1979

Age, Sex, Race, and Census Region	Disabled Hospital Insurance Enrollees (thousands)		Discharges		Covered Days of Care			Reimbursements			
	Number (thousands)	Per 1,000 Enrollees	Number (thousands)	Per 1,000 Enrollees	Number (thousands)	Per Discharge	Per 1,000 Enrollees	Total Amount (millions)	Per Discharge	Per Covered Day of Care	Per Enrollee
Total	2,911	399	1,161	399	11,163	9.6	3,835	\$2,153	\$1,855	\$193	\$740
Age											
Under 35	361	305	110	305	1,053	9.6	2,917	228	2,069	216	632
35-44	356	351	125	351	1,152	9.2	3,236	231	1,847	200	649
45-54	658	403	265	403	2,456	9.3	3,733	468	1,768	191	711
55-59	642	408	262	408	2,516	9.6	3,919	475	1,813	189	740
60-64	893	447	399	447	3,986	10.0	4,464	751	1,882	188	841
Sex											
Male	1,837	370	679	370	6,330	9.3	3,446	1,230	1,812	194	670
Female	1,073	449	482	449	4,833	10.0	4,504	923	1,916	191	860
Race											
White	2,388	406	970	406	9,157	9.4	3,835	1,742	1,796	190	729
All Other Races	471	352	166	352	1,758	10.6	3,732	361	2,175	205	766
Region											
Northeast	624	364	227	364	2,571	11.3	4,120	495	2,182	193	793
North Central	660	433	286	433	2,930	10.2	4,439	582	2,035	199	882
South	1,055	432	456	432	4,086	9.0	3,873	678	1,486	166	643
West	473	385	182	385	1,491	8.2	3,152	386	2,117	259	816

SOURCE: Medpar: Inpatient Hospital Stay Record File, unpublished data.

of care, but the lowest average length of stay. (For further discussion of geographic differences, see Gornick, 1982.)

HI also covers services in participating skilled nursing facilities (SNF's) for up to 100 days in a benefit period. For the first 20 days, patients pay no coinsurance. The remaining 80 days require a coinsurance equal to one-eighth of the inpatient deductible (\$32.50 in 1982). A beneficiary is eligible for SNF benefits only after hospitalization for at least three consecutive days and only if the transfer to an SNF occurs within 14 days after hospital discharge. The 1980 legislation increased that period to 30 days.

Data on the use of SNF's by aged and disabled enrollees in 1980 are reported in Tables 3.12 and 3.13. Information on aged and disabled persons served and reimbursements are shown by age, sex, race, and region.

Overall, the proportion of the elderly who received SNF benefits was much higher than that of the disabled—9.9 persons served per 1,000 aged enrollees compared with 2.9 per 1,000 disabled enrollees. Reimbursements per person served, however, were 18 percent higher for the disabled than the aged. For both aged and disabled enrollees, the number of persons served as well as total reimbursements increased with age while reimbursements per person served decreased with age. Among both the aged and the disabled, higher proportions of females than males received SNF benefits, and females also received higher reimbursements per person served. For both aged and disabled enrollees rates were much higher among white persons served per 1,000 enrollees than among persons of other races. Conversely, reimbursements per person served were much higher for persons of races other than white than for white persons. The number of persons served per 1,000 aged and disabled enrollees was lowest in the South and highest in the West. Reimbursements per person served were lower in the South and West than in the Northeast and North Central regions for both aged and disabled enrollees.

The third type of benefit covered by HI is home health agency (HHA) services for persons confined to the home and needing part-time or intermittent skilled nursing care or therapy. Covered services include skilled nursing care; physical, occupational or speech therapy; part-time or intermittent services of a home health aide; medical supplies (other than drugs and biologicals); the use of medical appliances; and, in certain cases, services of an intern or resident. The services must be furnished by an approved HHA.

Table 3.14 presents data on the use of HHA services in 1980.¹⁴ Unlike other tables in this chapter, these data include information on all users, not just those who satisfied the deductible. The number of users per 1,000 enrollees was 54 percent higher for aged enrollees than for the disabled. Reimbursements per user, however, were 17 percent higher for disabled (\$797), than for aged users (\$684). Among aged enrollees, a higher proportion of those 75 years of age and over use HHA services than those under 75. Enrollees who were 75 years of age and over represented 36 percent of all Medicare enrollees, but they accounted for 58 percent of all HHA reimbursements. Higher proportions of females and persons of races other than white used HHA services than did

males and white persons, respectively.¹⁵ In addition, reimbursements per user were higher for persons of races other than white than for white persons.

3. Benefits Under SMI

The SMI program covers physicians' services, including visits to the home, office, hospital, and other institutions. The program also pays for other services and supplies, such as drugs and biologicals that cannot be self-administered, if they are furnished as a part of a physician's professional services; diagnostic X-ray tests; diagnostic laboratory tests, and other diagnostic tests; X-rays, radium, and radioactive isotope therapy; splints, casts, and other devices used for reduction of fractures and dislocations; purchase or rental of durable medical equipment; ambulance services; and prosthetic devices that replace all or part of a body organ. In addition, SMI pays for outpatient services received in hospitals, rural health centers, community health centers, and renal dialysis centers; and outpatient rehabilitation, and speech and physical therapy services. Effective July 1, 1973, the 1972 amendments provided for coverage of services of physical therapists in independent practice furnished in their office or the patient's home, if under a physician's plan. The reimbursement limit for these services was increased from \$100 to \$500 by the 1980 Omnibus Budget Reconciliation Act. Lastly, limited chiropractic and optometric services are also covered.

During each calendar year, enrollees must exceed the SMI deductible to be reimbursed. From 1973 through 1981 the annual deductible was \$60 of reasonable charges; beginning in 1982, it was increased to \$75. Up to October 1981, medical expenses incurred in the last 3 months of a year were "carried over" to the following year's deductible. This provision was eliminated by the 1981 Act for expenses incurred beginning October 1981.

After the deductible has been met, SMI pays 80 percent of reasonable charges for covered physicians' services and most other medical services. The reasonable charge may not exceed the lowest of (1) the physician's or the supplier's customary charge for the service, (2) the prevailing charge in the locality for similar services, or (3) the charge applicable for comparable services under comparable circumstances to the policyholders or subscribers of the carrier. Since 1973, annual increases in prevailing charges have been limited by an economic index which reflects increases in providers' expenses and increases in general earnings. On each claim for payment, physicians can accept or reject assignment. Accepting assignment means that the physician submits the bill to the carrier and agrees to accept 80 percent of the reasonable charge. The patient is responsible for the deductible and the remaining 20 percent of the reasonable charge. The physician who does not accept assignment bills the patient. The patient is responsible for the total charge of the physician. The patient submits the bill to the carrier. The carrier pays the patient 80 percent of the reasonable charge after the deductible is met.

The charges of independent laboratories accepting assignment are paid at 100 percent of the rate negotiated between DHHS and the specific laboratory, with no deductible and coinsurance requirements. Outpatient

¹⁴These data include services and reimbursements paid for under both the hospital insurance and the supplementary medical insurance programs. See footnote 12.

¹⁵In addition to describing differences in the use of health services by demographic characteristics, the paper by Silverman cited in Table 3.14 discusses the patterns of services rendered by the different types of home health agencies.

TABLE 3.12

Use of Skilled Nursing Facilities by Aged Medicare Enrollees, by Age, Sex, Race, and Census Region, 1980

Age, Sex, Race, and Census Region	Aged Hospital Insurance Enrollees ¹ (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	25,103.7	247.8	9.9	\$331.0	\$1,336	\$13.19
Age						
65-69	8,301.7	22.1	2.7	33.1	1,494	3.99
70-74	6,592.1	36.5	5.5	51.1	1,401	7.75
75-79	4,731.0	53.1	11.2	72.0	1,356	15.22
80-84	3,072.4	61.1	19.9	80.2	1,312	26.10
85 & Over	2,406.5	75.0	31.2	94.6	1,261	39.31
Sex						
Male	10,156.2	80.4	7.9	101.8	1,267	10.02
Female	14,947.5	167.4	11.2	229.1	1,369	15.33
Race ²						
White	22,244.2	227.0	10.2	298.5	1,315	13.42
All Other Races	2,160.1	15.0	6.9	24.8	1,656	11.48
Region						
Northeast	5,915.4	53.2	9.0	80.4	1,511	13.59
North Central	6,575.8	72.5	11.0	99.0	1,367	15.06
South	7,973.9	63.3	7.9	78.5	1,241	9.84
West	4,131.9	58.0	14.0	72.0	1,242	17.43

¹ As of July 1, 1980.² Excludes persons of unknown race.

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.13

Use of Skilled Nursing Facilities by Disabled Medicare Enrollees, by Age, Sex, Race, and Census Region, 1980

Age, Sex, Race, and Census Region	Disabled Hospital Insurance Enrollees ¹ (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	2,963.2	8.5	2.9	\$13.4	\$1,571	\$4.51
Age						
Under 35	371.2	0.4	1.0	0.6	1,679	1.64
35-44	369.5	0.6	1.5	0.9	1,652	2.54
45-54	657.5	1.4	2.1	2.1	1,547	3.23
55-59	649.3	2.0	3.1	3.2	1,576	4.92
60-64	915.7	4.2	4.6	6.5	1,557	7.10
Sex						
Male	1,870.5	4.5	2.4	6.9	1,558	3.71
Female	1,092.6	4.0	3.7	6.4	1,586	5.88
Race ²						
White	2,422.2	7.1	2.9	10.9	1,526	4.49
All Other Races	486.7	1.1	2.4	2.1	1,833	4.32
Region						
Northeast	634.3	1.6	2.6	2.9	1,769	4.59
North Central	666.5	2.6	3.8	4.2	1,635	6.27
South	1,079.0	2.3	2.2	3.3	1,406	3.06
West	478.6	1.9	4.0	2.9	1,536	6.09

¹ As of July 1, 1980.² Excludes persons of unknown race.

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.14

**Users of and Reimbursements for Home Health Agency Services: Medicare Enrollees
by Type, Age, Sex, and Race, 1980**

Type, Age, Sex, and Race	Total Enrollees (thousands)	Users		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per User	Per Enrollee
Total	28,478.2	957.4	33.6	\$662.1	\$692	\$23.25
Type of Enrollee						
Aged	25,515.1	890.4	34.9	608.7	684	23.86
Disabled	2,963.2	67.0	22.6	53.4	797	18.02
Age						
Under 65	2,963.2	67.0	22.6	53.4	797	18.02
65-74	15,214.8	323.4	21.3	221.7	686	14.57
75 & Over	10,300.3	567.0	55.0	387.0	683	37.57
Sex						
Male	12,138.6	346.3	28.5	235.9	681	19.43
Female	16,339.7	611.1	37.4	426.2	697	26.08
Race						
White	24,955.9	826.9	33.1	561.1	679	22.48
All Other Races	2,743.7	106.9	39.0	84.7	792	30.87
Unknown	778.7	23.6	30.3	16.3	691	20.93

SOURCE: Medicare Program Statistics Branch, Home Health Agency Person File, 1980, unpublished.

hospital services are subject to the SMI deductible and coinsurance, but, like hospital services are reimbursed for reasonable costs. Outpatient treatment for mental illness is also subject to the deductible and coinsurance and benefits are also limited to the lesser of 50 percent of reasonable charges or \$250.

Table 3.15 reports SMI data on average charges and reimbursement rates per enrollee. Data are presented for 1967 through 1979 by type of enrollee. Reimbursements are estimated by subtracting deductible and coinsurance amounts from reasonable costs or charges for each enrollee. Charges to enrollees exceeding reasonable charges are excluded.

In 1979, Medicare reimbursements under SMI covered 73 percent of the reasonable costs or charges of all covered services for both aged and disabled enrollees. In 1967, the program reimbursed only 57 percent of reasonable costs or charges to aged enrollees. In that year, reasonable costs or charges were \$109.36 per enrollee, and reimbursements were \$62.39 per enrollee. Reimbursements are 80 percent of reasonable charges after subtracting the SMI deductible. Reasonable charges per enrollee rose nearly 300 percent between 1967 and 1979 while the SMI deductible rose only 20 percent in the same period (from \$50 to \$60 a year). Because the deductible became smaller in relation to reasonable charges, reimbursements as a percent of reasonable charges increased. In 1974, the first full year of coverage for the disabled, Medicare reimbursed 66 percent of

reasonable costs or charges to the disabled. Reasonable costs or charges were \$179.23 per disabled enrollee, and reimbursements were \$117.59 per enrollee. By 1979, reasonable costs or charges for both the aged and disabled rose to \$402 per enrollee; reimbursements rose to \$292 per enrollee. Physicians' services for both the aged and disabled were the major share, 75 percent, of SMI reimbursements in 1979. The proportion of reasonable charges reimbursed to all enrollees for physicians' services, in 1979, was slightly higher than that for all services. Inpatient radiology and pathology services were reimbursed at 100 percent of reasonable charges through May 1981. Home health agency services had higher than average reimbursement proportions because Medicare pays 100 percent of reasonable costs for these services. The 1972 Social Security Amendments eliminated coinsurance payments for home health services under SMI.

Tables 3.16 and 3.17 provide data on physicians' and other medical services used in 1980 by aged and disabled enrollees, respectively. The number of persons served per 1,000 enrollees was 6 percent higher for aged enrollees (633) than for disabled enrollees (600). Reimbursement per person served, however, was 30 percent higher for disabled enrollees (\$611 versus \$471). As a result, reimbursements per enrollee were 23 percent higher for disabled than aged enrollees. For both types of enrollees using physicians' services, the number of persons served per 1,000 enrollees was higher for older age groups. With the exception of the oldest age group,

TABLE 3.15

**Average Supplementary Medical Insurance Charges and Average Reimbursement Rates Per Enrollee,
by Type of Service and Enrollee Group, 1967-1979**

Year Ending 6/30	Average Enroll- ment (thousands)	All Services ¹			Physicians' Services ²			Inpatient Radiology & Pathology Services ³			Outpatient Services			Home Health Agency Services			Group Practice Prepayment Plan Services			Independent Laboratory Services		
		Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment	Reason- able Cost or Charge	Reim- burse- ment			
Aged																						
1967	17,750	\$109.36	\$62.39	\$103.55	\$59.08	NA ⁴	NA ⁴	\$ 1.89	\$ 1.89	\$ 1.41	\$ 2.47	\$ 1.38	\$0.79	\$1.55	\$0.88	\$0.41	\$0.23					
1968	18,038	128.14	80.01	117.21	72.53			6.57	6.57	2.40	3.88	2.41	1.49	2.18	1.35	.57	.35					
1969	18,833	145.58	93.72	126.11	79.06			7.14	7.14	4.23	6.74	3.06	1.92	2.46	1.54	.64	.40					
1970	19,312	154.02	99.90	131.18	82.84			7.21	7.21	5.93	9.39	3.16	2.00	2.39	1.51	.76	.48					
1971	19,664	162.52	106.27	137.67	87.80			7.21	7.21	7.56	11.85	2.63	1.68	2.21	1.41	.95	.61					
1972	20,043	173.14	114.22	146.82	94.82			6.77	6.77	8.58	13.28	2.49	1.61	2.57	1.66	1.21	.78					
1973	20,428	186.52	122.35	157.39	100.92			6.99	6.99	9.45	14.73	3.01	2.17	2.93	1.88	1.47	.94					
1974	20,988	204.39	134.26	171.28	109.94			7.44	7.44	11.35	17.69	2.53	2.03	3.58	2.30	1.87	1.20					
1975	21,504	235.91	159.61	192.09	126.94			8.70	8.70	15.48	23.43	4.65	3.84	4.57	3.02	2.47	1.63					
1976	22,089	270.74	187.60	213.62	144.42			10.84	10.84	21.30	31.50	6.16	5.21	5.66	3.83	2.96	2.00					
1977	22,605	311.56	220.00	240.30	165.76			12.17	12.17	28.72	41.63	7.58	6.54	6.34	4.37	3.54	2.44					
1978	23,133	356.12	255.68	275.80	193.53			14.84	14.84	33.47	47.70	7.77	6.82	5.83	4.09	4.18	2.93					
1979	23,693	401.70	291.68	308.93	219.63			16.47	16.47	40.69	57.23	7.52	6.68	6.89	4.90	4.66	3.31					
Disabled (excluding ESRD-only)																						
1974	1,636	179.23	117.59	141.65	90.23			7.54	7.54	13.93	21.87	4.35	3.46	2.95	1.88	.87	.55					
1975	1,813	220.30	150.09	176.45	117.39			8.40	8.40	17.37	26.11	4.32	3.59	3.44	2.29	1.58	1.05					
1976	2,015	256.08	178.69	202.11	137.70			9.99	9.99	21.74	31.91	6.03	5.14	3.93	2.68	2.11	1.44					
1977	2,229	307.53	219.50	229.88	160.44			12.92	12.92	36.56	52.38	5.50	4.80	4.06	2.83	2.79	1.95					
1978	2,419	353.51	256.05	265.54	188.40			14.19	14.19	42.83	60.37	6.27	5.56	3.52	2.50	3.62	2.57					
1979	2,560	406.85	298.40	309.35	222.43			17.19	17.19	47.53	66.10	5.73	5.15	4.03	2.90	4.45	3.20					

¹ Figures vary from other tables in this report. These figures are actuarial estimates from a 0.1 percent sample of all aged and 1.0 percent sample of all disabled enrollees. Reimbursements are estimated by subtracting deductibles and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceeds amounts the program deems reasonable are excluded.

² The figures vary from those in Tables 3.16 and 3.17 as explained in note 1. Also data in Tables 3.14 and 3.15 are for physicians' and other medical services while these data are only for physicians' services.

³ Includes services on payment records and those using combined billing: amounts shown are for April 1968 and later, when combined billings are authorized and inpatient radiology and pathology charges are reimbursed at 100 percent.

⁴ Inpatient radiology and pathology services were reimbursed by the HI program prior to April 1, 1968.
NA = Not applicable.

SOURCE: The Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 1981 Annual Report, July 8, 1981, pp. 41-42.

TABLE 3.16

Use of Physicians' and Other Medical Services by Aged Medicare Enrollees,
by Age, Sex, Race, and Census Region, 1980

Age, Sex Race, and Census Region	Aged Supplementary Medical Insurance Enrollees ¹ (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	24,680.4	15,627.0	633.2	\$7,361.4	\$471.07	\$298.27
Age						
65-69	8,155.8	4,665.0	572.0	2,033.9	435.99	249.38
70-74	6,570.3	4,053.8	617.0	1,894.4	467.32	288.33
75-79	4,683.8	3,123.0	666.8	1,548.1	495.73	330.52
80-84	2,981.4	2,087.8	700.3	1,048.3	502.10	351.61
85 & over	2,289.2	1,697.4	741.5	836.7	492.93	365.50
Sex						
Male	9,867.7	5,951.9	603.2	3,183.7	534.90	322.64
Female	14,812.7	9,675.1	653.2	4,177.6	431.79	282.03
Race ²						
White	21,875.5	13,991.6	639.6	6,622.5	473.32	302.74
All Other Races	2,113.6	1,217.8	576.2	551.6	452.95	260.98
Region						
Northeast	5,884.4	3,924.8	667.0	1,878.4	478.60	319.22
North Central	6,519.8	3,944.3	605.0	1,687.4	427.81	258.81
South	7,948.5	4,925.7	619.7	2,251.6	457.11	283.27
West	4,095.0	2,755.1	672.8	1,515.5	550.07	370.09

¹ As of July 1, 1980.

² Excludes persons of unknown race.

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.17

Use of Physicians' and Other Medical Services by Disabled Medicare Enrollees,
by Age, Sex, Race, and Census Region, 1980

Age, Sex Race, and Census Region	Disabled Supplementary Medical Insurance Enrollees ¹ (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	2,719.2	1,631.4	599.9	\$996.9	\$611.10	\$366.62
Age						
Under 35	339.7	162.8	479.3	108.8	668.46	320.41
35-44	337.1	176.8	524.3	113.7	643.42	337.32
45-54	596.3	345.7	579.7	216.0	624.72	362.17
55-59	592.5	362.3	611.4	219.2	605.12	369.95
60-64	853.6	583.8	684.0	339.2	580.96	397.37
Sex						
Male	1,694.6	921.1	543.6	556.5	604.15	328.39
Female	1,024.7	710.3	693.2	440.4	620.10	429.84
Race ²						
White	2,218.2	1,341.8	604.9	814.2	606.81	367.07
All Other Races	449.8	252.9	562.3	161.0	636.85	358.08
Region						
Northeast	589.5	371.6	630.4	225.8	607.75	383.10
North Central	619.8	371.9	600.0	216.2	581.40	348.84
South	1,013.8	571.6	563.8	334.1	584.49	329.53
West	448.4	302.6	675.0	214.2	707.76	477.74

¹ As of July 1, 1980.

² Excludes persons of unknown race.

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

reimbursement per aged person served also was higher for older than for younger enrollees. The reverse was true for disabled enrollees. Proportionately more women than men received benefits in both enrollee groups, although reimbursement per person served was 24 percent higher for aged men than for aged women. By sex, among the disabled, average reimbursements per person served were similar. The number of persons served per 1,000 enrollees was higher for white persons than for persons of other races in both enrollment groups. Reimbursement per person served was higher for aged white persons than for aged persons of other races. The opposite was true among disabled persons served. Data by region show that aged and disabled enrollees living in the West had both the highest rate of persons served per 1,000 enrollees and the highest amount reimbursed per person served. Aged enrollees living in the North Central region had both the lowest rate of persons served per 1,000 enrollees and amount reimbursed per person served.

Table 3.18 shows, for 1979, total charges for physicians, reasonable charges as determined by carriers, and amounts reimbursed by Medicare. For both aged and disabled enrollees combined, the reduction in reasonable charges was 21.6 percent and varied little by region. The percent reduction was highest in the North Central and lowest in the West. Medicare reimbursed 58.3 percent of physicians' charges after carriers made reasonable charge reductions and subtracted deductible and coinsurance amounts. The proportion of reimbursements to physician charges differed only slightly by region.

Tables 3.19 and 3.20 present data on outpatient services provided to aged and disabled enrollees. In 1980, aged enrollees received \$1,261 million in reimbursements while disabled enrollees received \$701 million. The disabled accounted for 36 percent of total reimbursements for outpatient services, though they represented 10 percent of all enrollees. Both the number of persons served per 1,000 enrollees and reimbursement per person served were higher for disabled than for aged enrollees. Reimbursement per person served was 4.1 times greater for the disabled (\$771) than for the aged (\$190). The highest amount reimbursed per person served was \$1,262 for disabled enrollees under age 35, reflecting the relatively high proportion of disabled persons with end-stage renal disease in this age group.

Among aged enrollees, the numbers of persons served per 1,000 enrollees using outpatient services differed only slightly by sex and race. Differences by sex in reimbursements per person served were also small. However, the amount reimbursed per person served was 58 percent greater for persons of races other than white than for white persons. Among disabled enrollees, the proportion of females who received benefits was 29 percent greater than the rate for males. Reimbursement per person served was also larger for females than for males, but by only 12 percent. By race there was a striking difference in reimbursements per person served—\$1,277 for persons of races other than white and \$646 for white persons. Persons of races other than white also had a higher rate of persons served per 1,000 enrollees. As a result, 31 percent of all reimbursements for outpatient services received by disabled enrollees went for persons of races other than white, though they were 16 percent of all disabled enrollees.

Table 3.21 reports data on covered hospital outpatient charges and reimbursements for aged and disabled enrollees (excluding those with ESRD), by census region in 1980. The percent of charges reimbursed were almost identical for both types of enrollees, 67.9 percent for the aged and 68.4 percent for the disabled, though the amount reimbursed per enrollee was about 50 percent higher for the disabled. Reimbursements per enrollee were lowest in the South and highest in the West, with about a twofold difference between the two regions. Differences in the percent of charges reimbursed varied much less by region, ranging from 66 percent in the Northeast to 73 percent in the West.

C. Financing

HI is financed primarily through a tax on a portion of current earnings in employment covered by the Social Security Act. Other sources of income (shown in Table 3.22) for the program, are: proceeds from the railroad retirement system, income to the trust fund appropriated from general revenues to reimburse the program for costs of noninsured enrollees, and interest earned by the fund. These monies are earmarked for the HI trust fund to pay benefits and administrative expenses.

The Federal SMI trust funds (Table 3.23) come from premiums paid by (or on behalf of) SMI enrollees, contributions of the Federal Government from the general fund of the Treasury, and interest from investments of the fund. At the start of Medicare, the monthly SMI premium was \$3.00. On July 1, 1982, the premium became \$12.20 per month. Until 1973, premiums were set to finance one-half the benefit and administrative costs of the SMI program, plus a contingency amount; general revenues financed the other one-half. The 1972 amendments altered that arrangement. Beginning July 1973, monthly premiums could be raised only if monthly social security cash benefits were increased. Furthermore, premiums could rise no more than the percentage increase in cash benefits. General revenues finance the benefit and administrative costs not covered through premiums.

In 1980, payroll taxes accounted for 91 percent of the HI trust fund's total income. The share of total income from payroll taxes has remained at about this level for the last several years. In the 1960's, the payroll tax share fluctuated between a high of 95.6 percent in 1966 and a low of 77.9 percent in 1968. Since 1968, benefit payments have accounted for over 97 percent of all HI disbursements. Since the 1972 Social Security Amendments, the major source of income for the SMI trust fund has been government contributions, which made up 69 percent of total income in 1980. Enrollees' premiums were 28 percent, the remainder was interest on investments.

D. Administration

1. Administration Under HI Intermediaries

Under HI, groups or associations of providers may nominate a national, State, or other public or private agency or organization to be their intermediary. Under an agreement with the Secretary of DHHS, the intermediary determines reasonable costs for covered items and services, makes payment, and guards against unnecessary use of covered services. The agreement may also (1) furnish consultative services to assist providers

TABLE 3.18

**Total Physicians' Charges, Reasonable Charges, and Reimbursements
to Aged and Disabled Medicare Enrollees, by Census Region, 1979**

Census Region	Charges (millions)		Percent Reduction in Total Charges	Reimbursements	
	Total	Reasonable		Total (millions)	As Percent of Total Charges
United States	\$9,622.2	\$7,543.2	21.6	\$5,607.7	58.3
Northeast	2,501.7	1,952.5	22.0	1,445.6	57.8
North Central	2,263.8	1,755.8	22.4	1,306.2	57.7
South	2,699.7	2,123.3	21.4	1,572.2	58.2
West	2,148.3	1,704.6	20.7	1,278.4	59.5

SOURCE: Analytical Studies Branch, Office of Research and Demonstrations, HCFA, unpublished data.

Table 3.19

**Persons Served and Reimbursements for Outpatient Services to Aged Medicare Enrollees,
by Age, Sex, and Race, 1980**

Age, Sex, and Race	Aged Supplementary Medical Insurance Enrollees ¹ (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	24,680.4	6,628.6	268.6	\$1,260.7	\$190.19	\$51.08
Age						
65-69	8,155.8	2,029.4	248.8	403.6	198.88	49.49
70-74	6,570.3	1,731.3	263.5	358.1	206.84	54.50
75-79	4,683.8	1,303.7	278.4	244.1	187.24	52.12
80-84	2,981.4	860.9	288.8	144.6	167.96	48.49
85 & over	2,289.2	703.2	307.2	110.3	156.85	48.18
Sex						
Male	9,867.7	2,571.7	260.6	529.9	206.05	53.70
Female	14,812.7	4,056.9	273.9	730.7	180.11	49.33
Race ²						
White	21,875.5	5,825.6	266.3	1,050.1	180.26	48.00
All Other Races	2,113.6	629.2	297.7	179.3	284.97	84.83

¹ As of July 1, 1980.

² Excludes persons of unknown race.

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.20

**Persons Served and Reimbursements for Outpatient Services to Disabled Medicare Enrollees,
by Age, Sex, and Race, 1980**

Age, Sex, and Race	Disabled Supplementary Medical Insurance Enrollees ¹ (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	2,719.2	909.2	334.4	\$700.7	\$ 700.64	\$257.68
Age						
Under 35	339.7	109.9	323.6	138.7	1,262.36	408.47
35-44	337.1	111.6	331.0	114.7	1,027.63	340.14
45-54	596.3	201.2	337.4	168.2	836.00	282.09
55-59	592.5	195.2	329.5	123.3	631.27	208.01
60-64	853.6	291.3	341.3	155.8	534.94	182.55
Sex						
Male	1,694.6	511.4	301.8	374.4	732.24	220.96
Female	1,024.7	397.9	388.3	326.3	820.00	318.41
Race ²						
White	2,218.2	719.9	324.6	465.3	646.35	209.78
All Other Races	449.8	170.5	379.0	217.7	1,277.06	484.01

¹ As of July 1, 1980.² Excludes persons of unknown race.

SOURCE: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.21

**Reimbursements for Hospital Outpatient Services to Medicare Enrollees,
by Type of Enrollee and Census Region, 1980**

Census Region	Covered Charges (millions)		Reimbursements					
			Total Amount (millions)		Per Enrollee		Percent of Charges	
			Aged	Disabled ¹	Aged	Disabled ¹	Aged	Disabled ¹
All Areas	\$1,496.5	\$244.3	\$1,015.7	\$167.1	\$41.15	\$62.07	67.9	68.4
United States	1,492.3	243.6	1,013.0	166.7	41.40	62.95	67.9	68.4
Northeast	454.9	73.5	298.0	48.5	50.64	83.21	65.5	66.0
North Central	380.5	50.2	253.7	33.9	38.92	55.20	66.7	67.5
South	348.4	62.4	236.4	41.9	29.75	41.74	67.9	67.3
West	308.5	57.5	224.8	42.4	54.90	95.52	72.9	73.7

¹ Excludes ESRD enrollees with hospital outpatient covered charges of \$303,349,000 and reimbursements of \$235,207,000.SOURCE: Charles Helbing, "Medicare: Use of Hospital Outpatient Services, 1980," *Health Care Financing Notes*, September 1983, Pub. No. 03163.

TABLE 3.22

Operations of the Medicare Hospital Insurance Trust Fund, Calendar Years 1966-1980
(millions)

Year	Transfers				Income			Disbursements				Trust Fund	
	Total Income	Payroll Taxes	From RR Retirement Account	Reimbursement for Uninsured Persons	Premiums from Voluntary Enrollees	Reimbursement for Military Wage Credits	Reimbursement for PSRO Review	Interest on Investment	Total Disbursements	Benefit Payments	Administrative Expenses	Net Change in Fund	Fund at End of Year
1966	\$ 1,943	\$1,858	\$ 16	\$ 26	NA	\$ 11	NA	\$ 32	\$ 999	\$ 891	\$108	+\$ 944	\$ 944
1967	3,559	3,152	44	301	NA	11	NA	51	3,430	3,353	77	+ 129	1,073
1968	5,287	4,116	54	1,022	NA	22	NA	74	4,277	4,179	99	+ 1,010	2,083
1969	5,279	4,473	64	617	NA	11	NA	113	4,857	4,739	118	+ 422	2,505
1970	5,979	4,881	66	863	NA	11	NA	158	5,281	5,124	157	+ 697	3,202
1971	5,732	4,921	66	503	NA	48	NA	193	5,900	5,751	150	- 168	3,034
1972	6,403	5,731	63	381	NA	48	NA	180	6,505	6,318	185	- 99	2,935
1973	10,821	9,944	99	451	\$ 2	48	NA	278	7,289	7,057	232	+ 3,532	6,467
1974	12,024	10,844	132	471	5	48	NA	523	9,372	9,099	272	+ 2,652	9,119
1975	12,980	11,502	138	621	7	48	NA	664	11,581	11,315	266	+ 1,398	10,517
1976	13,766	12,727	143	0 ²	9	141	NA	746	13,679	13,340	339	+ 88	10,605
1977	15,856	14,114	0 ¹	803 ²	12	143 ³	NA	784	16,019	15,737	283	- 163	10,442
1978	19,213	17,324	214 ¹	688	13	141	\$29	805	18,178	17,682	496	+ 1,035	11,477
1979	22,825	20,768	191	734	16	141	33	942	21,073	20,623	450	+ 1,751	13,228
1980	26,097	23,848	244	697	18	141	33	1,116	25,577	25,064	512	+ 521	13,749

¹ No transfer was made in 1977 because of a change in the transfer dates from August to June. The 1978 transfer is for contributions during the five-quarter period covering the transition quarter and fiscal year 1977.

² No transfer was made for 1976 because of the change in transfer dates from December to March. The 1977 transfer was for benefits and administrative expenses during the 15-month period beginning July 1976 and ending September 1977.

³ Includes \$2 million in reimbursement from general revenues for costs arising from the granting of noncontributory wage credits to persons of Japanese ancestry who were interned during World War II.

NA: Not applicable.

SOURCE: The Board of Trustees, Federal Hospital Insurance Trust Fund, 1981 *Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, July 8, 1981, p. 26.

TABLE 3.23

Operations of the Medicare Supplementary Medical Insurance Trust Fund, Calendar Years 1966-1980
(millions)

Year	Income			Disbursements			Trust Fund		
	Total Income	Premiums from Enrollees	Government Contributions ¹	Interest on Investments	Total Disbursements	Benefit Payments	Administrative Expenses	Net Change in Fund	Fund at End of Year ²
1966	\$ 324	\$ 322	\$ 0	\$ 2	\$ 203	\$ 128	\$75	+\$122	\$ 122
1967	1,597	640	933	24	1,307	1,197	110	+ 290	412
1968	1,711	832	858	21	1,702	1,518	183	+ 9	421
1969	1,839	914	907	18	2,061	1,865	196	- 222	199
1970	2,201	1,096	1,093	12	2,212	1,975	238	- 11	188
1971	2,639	1,302	1,313	24	2,377	2,117	260	+ 262	450
1972	2,808	1,382	1,389	37	2,614	2,325	290	+ 193	643
1973	3,311	1,550	1,705	57	2,844	2,526	318	+ 468	1,111
1974	4,124	1,804	2,225	95	3,728	3,318	410	+ 395	1,506
1975	4,673	1,918	2,648	106	4,735	4,273	462	- 62	1,444
1976	5,977	2,060	3,810	107	5,622	5,080	542	+ 355	1,799
1977	7,805	2,247	5,385	172	6,505	6,038	467	+1,300	3,099
1978	9,056	2,470	6,287	299	7,755	7,252	503	+1,301	4,400
1979	9,768	2,719	6,645	404	9,265	8,708	557	- 502	4,902
1980	10,874	3,011	7,455	408	11,245	10,635	610	- 372	4,530

¹ The payments shown as being from the general fund of the Treasury include certain interest-adjustment items.² The financial status of the program depends on both the total net assets and the liabilities of the program.

SOURCE: The Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 1981 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, July 8, 1981, p. 22.

in establishing and maintaining the fiscal records needed to qualify as providers of service; (2) serve as a center for communicating with providers; and (3) audit provider records. HI intermediaries also make payments for home health and outpatient hospital services covered by SMI.

Reasonable costs of services are determined by regulations of the Secretary of DHHS. Payment for covered services generally are submitted by the provider and are reimbursed for reasonable costs of covered services, less the deductible and coinsurance amounts. The beneficiary pays these amounts and pays for non-covered services.

The provider's intermediary reviews claims for payment and pays the provider. Payment for claims are made on the basis of interim rates established between the provider and the intermediary. Final settlement for each provider's operating year is based on a cost report of the provider, and subject to an independent audit.

Table 3.24 summarizes workload and cost data for HI intermediaries from 1975 through 1980. Although the number of bills processed increased 62.7 percent in that period, administrative costs increased by only 47.5 percent.

2. Administration Under SMI Carriers

The Secretary of DHHS contracts with carriers to perform certain administrative duties. A carrier computes reasonable charges and makes payments. Carriers also determine whether claims are for covered services and denies claims for noncovered services. Also, carriers deny claims for unnecessary use of services.

Claims for SMI benefits may be submitted to the carrier by the patient or by the provider. If patients submit claims (itemized bills) directly to the carrier, they receive direct payment for covered services but remain responsible for the physician's (or supplier's) bill.

A physician or other supplier of services may accept assignment: the provider accepts the reasonable charge as determined by the carrier as the total charge. The physician (or supplier) submits the bill and the carrier reimburses 80 percent of the reasonable charge. The patient is then responsible for the remaining 20 percent of the allowed charge and for the deductible, if applicable to the current bill. Table 3.25 presents workload and cost data for SMI carriers.

E. Group Practice Prepayment Plans and Health Maintenance Organizations

Group practice prepayment plans (GPPP's) and Health Maintenance Organizations (HMO's) are prepaid health plans that render physicians' services and other health care services to voluntarily enrolled subscribers in return for predetermined premium payments. This differs from the more common method of payment on a per visit or per service basis.

Prepaid health plans that provide services to Medicare enrollees have several options for participation in Medicare. They may contract to deal directly with Medicare either under Section 1833 as GPPP's or under Section 1876 as HMO's. HMO's may contract on a cost reimbursement basis or on a risk basis. Plans that do not contract directly with Medicare are "carrier dealing" plans, billing and receiving reimbursement through the regular Medicare fee-for-service billing procedures.

Medicare beneficiaries, in all cases, pay the plan (or have paid on their behalf through employment or retirement benefits) a supplementary premium to cover the Medicare deductible and coinsurance, and any benefits or services provided by the plan but not covered by Medicare.

The number of contracting GPPP's and HMO's and their Medicare members are shown by size of Medicare membership in Table 3.26. As of March 1982, the 88 contracting GPPP's/HMO's had a total of 630,497 Medicare members, about 2 percent of the total Medicare population. The four largest plans—all of them contracting as GPPP's—accounted for almost two-thirds of all Medicare members.

1. Group Practice Prepayment Plans (Section 1833)

Section 1833 was written into the original Medicare legislation to enable GPPP's to participate in Medicare with minimal constraints. GPPP's are paid monthly interim payments for Part B physicians' and related services based on estimated allowed costs per Medicare beneficiary and the number of Medicare member-months covered. At the end of the fiscal year, there is a post-audit adjustment based on the portion of audited physician and related costs allocated to Medicare members. Other Medicare-covered services provided by the plan are billed on a charges-related-to-cost basis, through the routine Medicare billing procedures (that is, through carriers and intermediaries). These services may include Part A hospital services, skilled nursing facilities, and home health agency services.

The GPPP legislation and regulations are nonrestrictive and a wide variety of plans are currently under Section 1833 contracts, including some of the oldest and largest plans in the country. Slightly under half of the 33 GPPP's shown in Table 3.26 are union/industrial plans that restrict membership to defined groups. Most of the others are nonprofit community plans with open membership, although most of their members may be under employment or retirement group contracts. Almost all of these community plans could become HMO's, and nine of them are Federally qualified HMO's but choose to remain under GPPP contracts.

In comprehensiveness of service, the GPPP's vary from little more than ambulatory primary care to a full range of services, including dental care, eye care, inpatient hospital, SNF care, and HHA services. Several GPPP's own or operate their own hospitals, SNF's, and HHA's. Medicare members of GPPP's may also use out-of-plan services and receive Medicare reimbursement for them. This provision allows Medicare members of GPPP's that do not provide comprehensive Medicare-covered services to receive full Medicare benefits. Reimbursement for out-of-plan services is through the routine Medicare billing process.

2. Health Maintenance Organizations (Section 1876)

The favorable cost experience of a few GPPP's led to the Federal policy of encouraging this form of delivery and payment for Medicare beneficiaries. In 1972, Section 1876 was added to the Medicare law to specify how and under what conditions HMO's may contract with Medicare. To encourage HMO's to enroll Medicare beneficiaries, the law gives them the opportunity to share in cost-savings resulting from efficient management and

TABLE 3.24

Medicare Hospital Insurance Intermediaries: Workload and Cost Data,¹ Fiscal Years 1975-1980

Fiscal Year	Number of Bills Processed (thousands)	Total Administrative Cost (millions)		Total Unit Cost		Administrative Cost ² (millions)		Unit Cost Excluding Audit		Provider Audit and Reimbursement (millions)	
		Index	Cost	Index	Cost	Index	Cost	Index	Cost	Index	Cost
1975	25,723.4	100.0	\$151.8	100.0	\$5.90	100.0	\$121.5	100.0	\$4.72	100.0	\$36.8
1976	25,898.7	112.3	164.8	108.6	5.70	96.6	133.0	109.4	4.60	97.5	39.7
1977	32,119.0	124.1	182.3	120.1	5.68	96.3	146.8	120.8	4.57	96.8	44.1
1978	34,862.4	135.5	191.3	126.0	5.49	93.1	141.8	116.7	4.07	86.2	47.7
1979	36,410.1	141.5	201.5	132.8	5.54	93.9	147.4	121.3	4.05	85.8	52.0
1980	41,846.7	162.7	223.9	147.5	5.35	90.7	157.8	129.9	3.77	79.9	64.0

¹ For 1975 set at 100.² For FY 1975, excludes Provider Audit cost.

For FY 1976 and 1977, excludes Provider Audit, PSRO and HMO costs.

For FY 1978, 1979 and 1980 excludes Provider Reimbursement, Provider Audit, PSRO and HMO costs.

SOURCE: Health Care Financing Administration, *Medicare Annual Report, Fiscal Year 1979*, p. 91, and *Analysis of Intermediaries' and Carriers' Administrative Costs, FY 1980*, Table A-6.

TABLE 3.25

Medicare Supplementary Medical Insurance Carriers: Workload and Cost Data,¹ Fiscal Years 1975-1980

Fiscal Year	Number of Claims Processed (thousands)	Total Administrative Cost (millions)		Claims Unit Cost		Payment Records Processed (thousands)		Payment Records Unit Cost	
		Index	Cost	Index	Cost	Index	Cost	Index	Cost
1975	80,613.7	100.0	\$258.7	100.0	\$3.21	100.0	63,837.4	100.0	\$4.05
1976	92,399.5	114.6	290.2	112.2	3.14	97.8	75,266.1	117.9	3.86
1977	108,126.3	134.1	322.6	124.7	2.98	92.8	88,983.8	139.4	3.63
1978	120,439.7	149.4	344.6	133.2	2.86	89.1	100,087.3	156.8	3.43
1979	133,494.9	165.6	375.3	145.0	2.81	87.5	112,864.6	176.8	3.32
1980	143,121.5	177.5	384.7	148.7	2.69	83.8	121,868.3	190.9	3.16

¹ FY 1975 set at 100.SOURCE: Health Care Financing Administration, *Medicare Annual Report, Fiscal 1979*, p. 94, and *Analysis of Intermediaries' and Carriers' Administrative Costs, FY 1980*, Table B-6.

TABLE 3.26

**Medicare Membership in Health Maintenance Organizations (HMO's)
and Group Practice Prepayment Plans (GPPP's): Number of Plans and Members
by Size of Membership, March 1982**

Size of Medicare Membership	All Plans		GPPP's		HMO's	
	Number of Plans	Medicare Members	Number of Plans	Medicare Members	Number of Plans	Medicare Members
Total	88 ¹	630,497	33	514,605	55	115,892
Under 100	7	157	0	0	7	157
100-499	14	3,618	4	897	10	2,721
500-999	20	14,418	5	4,232	15	10,186
1,000-4,999	28	64,418	12	31,234	16	33,184
5,000-9,999	10	75,808	4	31,451	6	44,357
10,000-19,999	4	50,659	4	50,659	0	0
20,000-49,999	1	25,287	0	0	1	25,287
50,000-99,999	3	270,187	3	270,187	0	0
100,000 and over	1	125,945	1	125,945	0	0

¹ The Portland Kaiser Plan is counted twice because it has an HMO demonstration contract for 7,500 Medicare members and a GPPP contract for 14,331 Medicare members.

SOURCE: Group Health Plans Operations Staff, HCFA.

use of resources by entering into risk-basis contracts. If they do not choose this option, or if they cannot meet the specifications for risk contracting, they may enter into cost-basis contracts.

Two major requirements of a contracting HMO are: (1) it must be certified as Federally qualified by the Office of Health Maintenance Organizations of the Public Health Service; and (2) it must make available to its Medicare enrollees, either directly or under contractual arrangements with area providers, all of the Medicare-covered services normally available to fee-for-service Medicare beneficiaries in its service area. (Developing HMO's are given 3 years to meet the latter requirements.) Thus, requirements for HMO's are considerably more stringent and restrictive than those for GPPP's.

As of March 1982, 55 HMO's with a total of nearly 116,000 Medicare members were under Section 1876 contracts. Of these, 45 were under cost contracts, only 2 were under normal risk contracts, and 8 others were under special experimental demonstration risk contracts. HMO's tend to have fewer Medicare enrollees than the GPPP's; only one has more than 10,000. They also tend to be newer and are more likely to be for-profit. All of them are community plans; union/industrial plans cannot become HMO's because of their closed membership.

Cost-contracting HMO's function very much like GPPP's in Medicare: (1) they receive monthly interim payments during the year based on their estimated allowed costs, with a post-audit adjustment to actual allowed costs at the close of the year; and (2) their Medicare members may use and receive Medicare reimbursement for out-of-plan services. A major difference is that the HMO payments may include all Part A and Part B services, as noted above, whereas the GPPP payments are limited to Part B physicians' and related medical services only, even if the GPPP also provides other Medicare-covered services to its Medicare members.

Section 1876 risk-contracting HMO's also receive interim payments during the year. However, in their post-audit adjustment, each HMO's savings (or losses) are determined by comparing its audited allowed costs per Medicare member with the "adjusted average *per capita* cost" (AAPCC) for its service area. The AAPCC is computed by applying a geographic index, specific to the HMO's service area, to the average *per capita* costs for all Medicare beneficiaries, then further adjusting for characteristics of the HMO's Medicare membership, including age, sex, institutionalized status, and welfare status. Separate Part A and Part B AAPCC's are calculated for Medicare aged and disabled beneficiaries. If the HMO's costs are higher than its AAPCC, it must absorb the loss or carry it over to be offset by future savings. If the risk-contracting HMO's costs are less than the AAPCC, it shares the "savings" with the Medicare program. The HMO may reserve savings of up to 10 percent of the AAPCC. The Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248, authorized prospective reimbursement under risk contracts with HMO's and other eligible organizations at a rate equal to 95 percent of the AAPCC. This provision will become effective the first day of the 13th month after enactment (enactment was September 1982), or one month after the Secretary notifies Congress that the method of determining the prospective rate can be implemented, whichever is later.

A major difference between risk HMO's and other contracting plans is that Medicare members of risk HMO's are "locked in" to the plans' services; that is, they cannot choose to use out-of-plan services and receive Medicare reimbursement for them. (Exceptions are emergency service and "urgently needed" out-of-area services). Thus, risk-contracting HMO's must make all Medicare-covered services available to Medicare members.

3. All Other Plans

Most prepaid health service plans do not contract with Medicare under either Section 1833 or Section 1876. The Office of Health Maintenance Organizations which publishes an annual survey of HMO's, lists a total of 243 HMO's as of June 1981 (National HMO Census, 1981).

F. The Medicare Statistical System

The Medicare Data System provides data for analyzing and evaluating the programs' effectiveness. The system consists of four major computer files: the health insurance master, the provider of service, the HI claims, and the SMI payment record files.

The health insurance master file contains records for each aged and disabled enrollee and indicates the type of entitlement and the enrollee's deductible status, benefit period status, and benefits used. This file provides population data for the program, and is the base in computing a variety of user rates by age, sex, race, and residence.

The provider of service file maintains information on hospitals, home health agencies, skilled nursing facilities, independent clinical laboratories, and suppliers of portable X-ray or outpatient physical therapy services who participate in Medicare. This file consists of data from the provider application for participation forms. For hospitals, it includes data on the number of beds, type of ownership, and other characteristics. Provider data are updated regularly.

The HI claims file maintains information on beneficiaries' entitlement and the extent to which enrollees have used covered benefits. When an enrollee uses a participating medical facility (for example, a hospital or skilled nursing facility), admission and billing forms are forwarded to HCFA's central office. This office records all "benefit period" information needed by carriers. This information includes stays in certain nonparticipating institutions and days of care not covered or reimbursable under the program. The admission and billing form contains both a Medicare enrollee identification number and a provider number. A computer tape record of this form when matched with enrollee entitlement and provider tapes forms a statistical research tape. The resulting tape provides enrollee, provider, use of service, and cost data for each enrollee. As part of the data sampling process, information on diagnoses and surgical procedures is obtained for a 20-percent sample of hospitalized enrollees.

The HCFA central SMI payment records are used to inform carriers if enrollees have met the deductible. They also provide information on amounts paid by carriers for physicians' services and for other SMI covered services and supplies. A bill summary file is derived from a 5-percent sample of the SMI payment record file, for statistical research.

The Medicare statistical system enables HCFA to prepare a wide variety of statistical and analytical reports and studies on the use and reimbursement of Medicare services. These data provide information about the use of benefits by enrollees for a point in time or over an extended period. Statistical reports are produced on enrollment, characteristics of participating providers, reimbursements, and services used.

Medicare is also implementing the Continuous Medicare History Sample (CMHS) beginning with 1974 data. The CMHS is designed to provide longitudinal data of Medicare program use from a sample of enrollees. The CMHS file consists of data from all of the Medicare user files for a number of years. Selected data from the enrollment and user files have been combined into one record for each sample person to acquire specific person data. The CMHS is a 5-percent probability sample by Medicare health insurance claim numbers. New enrollees whose health insurance claim numbers place them in the CMHS are added to the sample, and the records of enrollees whose Medicare coverage ends are retained in the file. The ability to link different data files over a period of years is a key feature of CMHS and the Medicare Data System. It permits detailed analysis of specific groups of enrollees over time.

IV. The Medicaid Program: Description and Data

This chapter presents detailed information on the Medicaid program, including eligibility criteria, recipient characteristics, benefit coverage, service use, expenditures, financing, and administration.¹⁶ Explanations of program requirements are based on Title 42 of the Code of Federal Regulations, Parts 430–450. Section A, on eligibility, describes Federal requirements and State options in defining the categorically and medically needy. Classes of eligibles covered and the income standards for eligibility are presented for each State. In Section B, data are presented on the distribution of recipients by State, by eligibility category, age, and sex.

Section C describes the Medicaid benefits offered by each State, including optional services, benefit limitations, and cost-sharing requirements. Section D presents data on the use of Medicaid-covered services. For each State, the data show the distribution of recipients by type of service used; the absolute number of recipients and total volume of services by service type; the number of EPSDT screenings and percent of screenings revealing a condition; and the number and types of sterilization procedures performed.

Section E focuses on Medicaid expenditures. The data show the distribution of State expenditures by eligibility category, age and sex of recipients, and by type of service. Comparisons of average expenditures per recipient by State and ratios of Medicaid recipients to persons at or below the poverty level are also presented. Section F describes Medicaid financing, including information on matching rates for Federal financial participation, the distribution of expenditures among Federal, State, and local governments, and recipients and expenditures covered under State buy-ins to Medicare.

Section G covers various topics in Medicaid administration, including provider reimbursement methods, expenditures for administrative training and nursing home surveyors, numbers of certified providers, administrative responsibility for eligibility determination, adoption of management and information systems, and fraud and abuse. Section H describes the Medicaid data system and the chapter concludes with a brief overview of changes in Federal Medicaid policy mandated by the Omnibus Budget Reconciliation Act of 1981.

A. Eligibility

Medicaid is a major component of the current welfare system and its eligibility provisions are among the most complex of all assistance programs. At a minimum, States must cover all persons who receive cash payments from either the Aid to Families with Dependent Children (AFDC) program or, in most cases, the Supplemental Security Income (SSI) program. States have the option of extending Medicaid coverage to the medically needy and to specified groups of people known as the optionally categorically needy. The medically needy are defined as categorically related individuals who are

ineligible for cash assistance on the basis of income and financial resources but whose income and resources are considered insufficient to meet their medical needs. This section describes the standards States use to determine who is eligible for Medicaid as either categorically or medically needy.

1. The Categorically Needy

As shown in Figure 4.1 the categorically needy include AFDC and SSI cash assistance recipients and may also include optional groups related to each cash assistance category. The AFDC and SSI categories are discussed in turn.

a) Aid to Families with Dependent Children (AFDC)

The Federal government offers the States a number of options for Medicaid coverage through their AFDC programs. State Medicaid programs *must* cover all persons receiving cash assistance under the State's AFDC plan as well as families terminated from cash assistance because of increased earnings or hours of employment. Prior to the enactment of the Omnibus Budget Reconciliation Act, 1981 (OBRA-81), States also were required to provide Medicaid coverage to anyone under 21 years of age who could qualify if he or she met age or school attendance requirements for AFDC. Section 2172 of OBRA-1981 dropped this requirement, making coverage of such individuals a State option. States now may limit such coverage to children under age 21, 20, 19, 18, or any other reasonable category of such children. At State option, the AFDC State Plan may include families with unemployed parents, and children 18 years of age who are regularly attending school.¹⁷ If the State extends

¹⁷Prior to October 1, 1981, each State had the option of extending AFDC eligibility to children 18 to 20 years of age who were regularly attending school, college or university, or a course of vocational or technical training. As of October 1, 1981, OBRA restricted this optional coverage to 18-year-olds who are full-time students in secondary school or the equivalent level of vocational or technical training and who can reasonably be expected to complete the program before reaching their 19th birthday. Before October 1, 1981, States also had the option under their AFDC program of extending Medicaid coverage to "unborn children". OBRA effectively deleted Medicaid benefits for "unborn children" under the AFDC program and substituted coverage of pregnant women in their place. In the interest of flexibility, States were temporarily allowed to continue covering "unborn children" under the AFDC dependent child clause described in section 435.222 of the Code of Federal Regulations (that is, individuals under 21 years of age who would be eligible for AFDC if they met the definition of a dependent child). The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 subsequently revised Medicaid law to provide coverage directly to pregnant women. TEFRA also extended direct coverage to "unborn children" previously provided on a temporary basis under Section 435.222.

¹⁶The numbers presented in the data tables may differ from those in previous publications, including those found in former editions of the data book. These differences are due mainly to the receipt by HCFA of late reports and adjustments.

FIGURE 4.1
Eligibility Coverage of the Categorically Needy, October 1, 1981

Categorically Needy

- Aged, Blind, Disabled, or Member of Family Unit Deprived of Support of Parent
- Income Standard
- Resource Standard

AFDC Recipients

Mandatory Coverage

- Individuals receiving AFDC payments
- Families terminated from AFDC because of increased earnings or hours of employment (Section 435.112)
- Individuals who are ineligible for AFDC because of requirements that do not apply under Title XIX of the Social Security Act (Section 435.113)
- Individuals who would be eligible for AFDC except for increased OASDI income under Public Law 92-336 (July 1, 1972) (Section 435.114)

Optional Coverage

- Eligible for but not receiving cash assistance (Section 435.210)
- Eligible for cash assistance but institutionalized (Section 435.211)
- Individuals who would be eligible if child care costs were paid from earnings (Section 435.220)
- Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children (Section 435.222)
- Individuals who would be eligible if coverage under State's AFDC plan where as broad as allowed under Title IV-A (Section 435.223)

SSI Recipients

Mandatory Coverage

- Individuals receiving SSI payments (Section 435.120)
- Individuals in States using more restrictive requirements for Medicaid than SSI (Section 435.121)
- Individuals ineligible because of requirements that do not apply under Medicaid (Section 435.122)
- Individuals receiving mandatory State supplements (Section 435.130)
- Institutionalized individuals eligible in December 1973 (Section 435.132)
- Blind and disabled individuals eligible in December 1973 (435.133)

Optional Coverage

- Eligible for but not receiving cash assistance (Section 435.210)
- Eligible for cash assistance but institutionalized (Section 435.211)
- Individuals receiving only optional State supplements (Section 435.230)
- Individuals in institutions who are eligible under a special income level (Section 435.231)

- Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (Section 435.135)
- Individuals eligible as essential spouses in December 1973 (Section 463.131)
- Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 (July 1, 1972) (Section 435.134)

AFDC coverage to these groups, it must extend Medicaid coverage as well.

At State discretion, a Medicaid program also may extend benefits to certain other "AFDC-related" groups. As shown in Table 4.1, these optional categorically needy groups include:¹⁸

- (1) Individuals who are eligible for but are not receiving cash assistance (Section 435.210);
- (2) individuals who are eligible for AFDC cash assistance except for their institutional status (Section 435.211);
- (3) individuals who would be eligible for AFDC payments if child care costs were paid from earnings (Section 435.220);
- (4) all persons under 21 years of age (or at State option, under age 20, 19 or 18) who meet the AFDC income and resource limits but do not meet the definition of a dependent child under the AFDC program. States may limit coverage to certain groups such as children in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities (ICF's) (Section 435.222);
- (5) persons who would be eligible for AFDC payments if the State AFDC program were as broad as Title IV-A of the Social Security Act allows (Section 435.223).

Income standards for cash assistance and Medicaid eligibility are set by the States. Table 4.2 presents the annual AFDC need and payment standards used by the States to determine Medicaid eligibility for AFDC recipients and the medically needy in those States with a medically-needy program. (See section 2 for a discussion of eligibility standards for the medically needy.) Data are shown for two family sizes (2 and 4 persons). Data for other family sizes are available from State public assistance plans.

The need standard is the amount of money a State determines essential to meet a minimal standard of living in that State for a specified family size. In general, the standard provides for basic consumption items such as food, clothing, shelter, fuel and utilities, personal care items, household items, and in certain cases, special or recurrent needs. Some States vary the need standard to reflect differences in actual cost within the State, others vary it by season, and one varies it according to the age of the child.

In addition to the need standard, the States also set the standard of payment for AFDC families. Payment standards show a wide range across Medicaid programs in this country, from a high of \$7,608 in Alaska to a low of \$1,776 in Alabama for four-persons families. (Table 4.2 does not include program data for the four territories of Guam, the N. Marianas, Puerto Rico, and the Virgin Islands.) For most States, the payment standard is the maximum amount of cash assistance that will be paid to a family with no countable income. Approximately one-half of the States set a payment standard that is lower than the need standard. It should be noted, however, that a State meeting less than full need (that is, a State with a payment standard below its established

need standard), but having a high need standard, may provide a substantially higher level of assistance than a State meeting full need under a relatively low need standard.

b) Supplemental Security Income

Prior to 1974, States had the same authority to set cash assistance and Medicaid eligibility standards for the aged, blind, and disabled as they had for the AFDC population. Since 1974, however, the Federal Supplemental Security Income (SSI) program has included minimum income standards for cash assistance to the aged, blind, and disabled. When the SSI program began, States were permitted to choose one of three ways to determine Medicaid eligibility for these persons. The Medicaid program could cover:

- (1) All persons receiving an SSI benefit, including their eligible spouses;
- (2) all persons receiving an SSI benefit or State supplementary payment, including their eligible spouses; or
- (3) all persons who met the eligibility criteria for medical assistance in effect on January 1, 1972, or some less restrictive criteria. These criteria must be more restrictive than the criteria for SSI benefits or State supplements and they must be applied to the individual's income after subtracting his or her SSI benefit, State supplementary payment, and incurred medical expenses. States taking this option are known as "209(b)" States and this deduction is referred to as the "209(b) spend-down."

States were also required to provide Medicaid coverage to the following groups which were eligible for Medicaid in December 1973:

- (1) individuals receiving a mandatory State supplementary payment (Section 435.130);
- (2) essential spouses (Section 435.131);
- (3) institutionalized individuals (Section 435.132); and
- (4) blind and disabled individuals (Section 435.133).

These requirements were established to prevent the loss of eligibility for cash assistance recipients in transition to SSI. Individuals could have lost eligibility if States narrowed their definitions of disability or visual impairment. To prevent this, on December 1973, recipients of Aid to the Blind (AB) and Aid to the Permanently and Totally Disabled (APTD) were deemed to meet the SSI criteria for disability or blindness in States with more liberal categorical definitions. Individuals also could have lost their eligibility if SSI used lower income and resource levels than their State had previously employed. Therefore, States with more liberal financial standards were required to pay the difference between the lower SSI benefit and the individual's previous cash benefit, and to extend Medicaid benefits to such individuals. This requirement is called mandatory supplementation. Although the mandatory supplement comes out of State revenues, it may at State option be administered by the Federal government.

To protect individuals in States choosing not to extend Medicaid coverage to all SSI recipients, the law required that all 209(b) States adopt a "spend-down" for Medicaid. In determining eligibility for Medicaid assistance, 209(b) States must exclude from the applicant's income, the SSI payment, and any optional State supplement an individual receives, as well as any medical expenses

¹⁸Prior to the enactment of OBRA-81, States also could extend coverage to another optionally categorically needy group known as "caretaker relatives". For further information see CFR 42, October 1, 1980.

TABLE 4.1

Medicaid Coverage under AFDC, by Jurisdiction, February 1982

Medicaid Jurisdiction	AFDC State Plan Includes			Optional Categorically Needy				
	Families with Unemployed Parents	Pregnant Women with No Other Eligible Children	Children Age 18 Regularly Attending School	All Financially Eligible Individuals Under Age 21	Individuals Eligible for but not Receiving Aid	Individuals Eligible but in Institutions	Individuals Who Would Be Eligible if AFDC is Broad as Social Security Act Allows	Individuals Who Would be Eligible if Child Care Cost Paid from Earnings
Alabama			X	X		X		
Alaska				X		X		
Arkansas				X		X		
California	X	X	X	X	X	X	X	X
Colorado	X	X	X	X	X	X		
Connecticut	X	X		X	X	X		
Delaware	X	X	X	X	X	X	X	X
District of Columbia						X		
Florida				X		X		
Georgia				X		X	X	
Hawaii	X	X	X	X	X	X		
Idaho		X	X	X	X	X		
Illinois	X		X		X	X		
Indiana						X		
Iowa								
Kansas	X	X	X				X	
Kentucky			X	X				
Louisiana		X	X	X		X	X	
Maine	X	X	X	X	X	X		
Maryland	X	X	X	X	X			
Massachusetts	X	X	X	X	X	X		
Michigan	X	X	X	X				
Minnesota	X	X	X	X		X	X	X
Mississippi						X		
Missouri	X		X			X		X
Montana	X	X	X	X	X	X		X
Nebraska	X	X	X			X		
Nevada				X				
New Hampshire				X	X			
New Jersey	X		X	X	X	X	X	
New Mexico		X	X					
New York	X	X	X		X	X	X	X
North Carolina		X	X		X			
North Dakota		X	X	X	X	X		X

continued

TABLE 4.1 (continued)
Medicaid Coverage under AFDC, by Jurisdiction, February 1982

Medicaid Jurisdiction	AFDC State Plan Includes				Optional Categorically Needy			
	Families with Unemployed Parents	Pregnant Women with No Other Eligible Children	Children Age 18 Regularly Attending School	All Financially Eligible Individuals Under Age 21	Individuals Eligible for but not Receiving Aid	Individuals Eligible but in Institutions	Individuals Who Would Be Eligible if AFDC is Broad as Social Security Act Allows	Individuals Who Would be Eligible if Child Care Cost Paid from Earnings
Ohio	X	X	X			X		X
Oklahoma			X	X	X	X	X	X
Oregon		X	X	X	X	X		
Pennsylvania	X	X		X	X	X	X	X
Rhode Island	X	X		X	X	X		
South Carolina						X		
South Dakota						X		
Tennessee		X		X		X		
Texas			X			X		
Utah		X		X		X		X
Vermont	X	X	X	X	X	X		X
Virginia			X		X	X		X
Washington		X	X	X	X	X		X
West Virginia	X	X			X			
Wisconsin	X	X	X	X	X	X	X	X
Wyoming		X	X					

SOURCE: State Plan Branch, Bureau of Program Operations, HCFA.

TABLE 4.2

**Annual AFDC Need and Payment Standards and Annual Net Income Levels
for Determining Medicaid Eligibility for the Medically Needy, by Jurisdiction**

Medicaid Jurisdiction	Annual Need and Payment Standards (February 1982)				Annual Net Income Protected for Maintenance of the Medically Needy (June 1982)			
	2 Person Family		4 Person Family		1 Person Family	2 Person Family	4 Person Family	6 Person Family
	Need	Payment	Need	Payment				
Alabama	\$1,728	\$1,068	\$2,880	\$1,776				
Alaska	6,096	6,096	7,608	7,608				
Arkansas	2,316	1,392	3,276	1,965	\$1,800	\$1,900	\$2,700	\$3,400
California	4,896	4,896	7,212	7,212	3,972	6,528	9,612	12,336
Colorado:	4,656	3,828	6,696	5,508				
Connecticut:	4,164	4,164	6,012	6,012				
Region A ²					3,900	5,300	7,000	8,800
Region B ²					3,600	5,000	6,100	7,800
Region C ²					3,500	4,800	5,900	7,600
Delaware	2,364	2,364	3,744	3,744				
District of Columbia	3,732	2,700	5,772	4,188	3,098	4,738	4,864	5,795
Florida	1,932	1,932	2,952	2,952				
Georgia	1,932	1,932	2,724	2,724				
Hawaii	4,680	4,680	6,552	6,552	3,600	4,800	6,600	8,400
Idaho	5,352	2,940	7,524	4,140				
Illinois	3,984	3,000	7,116	4,416	2,856	3,996	4,416	5,940
Indiana ³	2,964	2,664	4,356	3,924				
Iowa	3,504	3,504	5,028	5,028				
Kansas	3,264	3,264	4,488	4,488	3,720	4,680	4,920	5,880
Kentucky	1,944	1,944	2,820	2,820	2,200	2,600	3,800	5,000
Louisiana:	3,468	1,500	5,928	2,556				
Urban					2,004	2,314	3,804	5,100
Rural					1,800	2,004	3,504	4,800
Maine	3,684	2,676	6,264	4,536	2,880	3,600	6,100	8,600
Maryland	2,532	2,532	3,912	3,912	2,904	3,408	4,404	5,400
Massachusetts ⁴	3,768	3,768	5,340	5,340	3,996	5,100	5,340	6,912
Michigan: ⁵	4,284	3,912	6,096	5,568				
Zone I ⁶					3,468	5,208	5,916	7,776
Zone II ⁶					3,468	5,208	5,796	7,656
Minnesota	4,416	4,416	6,240	6,240	3,526	4,410	6,240	7,860
Mississippi ³	2,256	2,256	3,024	3,024				
Missouri	3,000	2,388	4,380	3,480				
Montana	4,043	3,084	5,676	4,704	3,180	4,104	5,700	7,596
Nebraska	3,360	3,360	5,040	5,040	3,400	4,500	6,300	8,100
Nevada	2,748	2,328	4,092	3,456				
New Hampshire	3,504	3,504	4,704	4,704	2,988	3,468	4,572	5,712
New Jersey	3,276	3,276	4,968	4,968				

continued

TABLE 4.2 (continued)

Annual AFDC Need and Payment Standards and Annual Net Income Levels
for Determining Medicaid Eligibility for the Medically Needy, by Jurisdiction

Medicaid Jurisdiction	Annual Need and Payment Standards (February 1982)				Annual Net Income Protected for Maintenance of the Medically Needy (June 1982)			
	2 Person Family		4 Person Family		1 Person Family	2 Person Family	4 Person Family	6 Person Family
	Need	Payment	Need	Payment				
New Mexico	2,268	2,268	3,372	3,372				
New York ⁵	2,076	2,076	3,564	3,564	3,700	5,300	5,500	6,500
North Carolina	4,224	2,114	5,340	2,652	2,200	2,900	3,600	4,200
North Dakota	3,240	3,240	4,896	4,896	3,180	4,520	6,360	7,980
Ohio	4,152	2,592	6,180	3,924				
Oklahoma	2,616	2,616	4,188	4,188	2,900	3,500	5,600	7,500
Oregon	3,432	3,432	4,908	4,908				
Pennsylvania	3,144	3,144	4,572	4,572	3,800	4,400	5,500	6,800
Rhode Island	3,872	3,872	5,488	5,488	4,600	5,100	7,200	9,200
South Carolina ³	1,728	1,224	2,748	1,956				
South Dakota	3,360	3,360	4,332	4,332				
Tennessee	1,704	1,212	2,604	1,884	1,404	1,620	2,460	3,348
Texas	1,464	1,464	2,412	2,412				
Utah	4,884	3,336	7,680	5,256	3,312	4,452	7,018	10,524
Vermont	7,116	4,908	9,708	6,696				
Chittendon Co.					3,888	5,748	6,696	8,184
All other areas					3,708	5,436	6,480	7,956
Virginia:								
Group I ⁷	2,712	2,436	4,068	3,660				
Group II ⁷					2,300	2,700	3,500	4,500
Group III ⁷					2,500	3,100	3,800	4,900
Washington	5,136	4,380	6,492	6,372	3,100	3,800	4,400	5,700
West Virginia	2,628	1,968	3,972	2,988	3,636	5,208	6,012	8,052
Wisconsin	5,544	4,812	7,944	6,756	2,400	2,700	3,300	4,296
Wyoming	3,360	3,360	4,080	4,080	4,373	6,500	7,944	9,864

¹ The following 20 States do not include the "medically needy" in the scope of their programs: Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas, and Wyoming.

² Annual gross income minus employment expense or other appropriate disregard.

³ The highest annual amount of maximum payment is lower than the payment standard.

⁴ Includes quarterly grant monies.

⁵ Michigan and New York have differentiated shelter cost areas; reported are Wayne County, Michigan shelter maximums.

⁶ Zones are based on geographical location with Counties assigned to areas within zones; Zone I consists of 6 Areas, Zone II consists of 5 Areas. The numbers shown represent the mean protected income for each zone.

⁷ Groups are composed of specific counties and cities based on cost of shelter differentials. In general, Group I is the south and western part of the State; Group II is the central part, and Group III is Northern Virginia.

SOURCES: Annual AFDC Need and Payment Standards—Office of Research and Statistics, Social Security Administration, DHHS; Annual Net Income Protected for Maintenance for the Medically Needy—State Plans Branch, Bureau of Program Operations, HCFA.

incurred by the individual. This 209(b) or categorically needy spend-down applies only to those categories for which more restrictive eligibility criteria are imposed, should the State elect not to impose more restrictive criteria on all categories. Although the provisions are directed primarily at States choosing to impose more restrictive income standards, these provisions are equally applicable if a State elects to impose any criteria that are more restrictive than those used under SSI. As a result of these provisions, even 209(b) States without a medically needy program must permit all individuals to spend-down; non-209(b) States, however, need not extend this coverage.

The option to cover certain additional groups as categorically needy was also offered to the States. These groups could be covered no matter which of the three basic coverage options was chosen by the State. They include (1) persons eligible for but not receiving cash assistance (Section 435.210), (2) certain institutionalized persons (Section 435.211 and 435.231), (3) individuals receiving only optional State supplements (Section 435.230), and, as of October 1, 1981, (4) individuals receiving home and community-based services (under Section 2176 of the OBRA-81) who are eligible under a special income level (Section 435.232). States electing to limit these payments to reasonable classifications of categorically related individuals. Table 4.3 shows the SSI-related groups eligible for Medicaid coverage in 1982.

2. The Medically Needy

The medically needy program is one of the most important overall options for coverage that can be exercised under the Medicaid program. The general intent of the medically needy option is to accommodate individuals who meet all criteria for categorically needy assistance with the exception of income, and who have incurred relatively large medical bills (Figure 4.2). Since 1969, a State's medically needy income standard has been limited to 133⅓ percent of the maximum AFDC assistance payment for a family of the same size. In other words, for Federal matching purposes, the Federal Government will recognize as medically needy only those persons whose "countable" income does not exceed 133⅓ percent of the maximum payment standard set by the State. Table 4.2 shows the annual income levels for the medically needy in those States with a medically needy program.

Before October 1981, each State was required to employ a single Statewide income standard when determining eligibility for medically needy individuals and families. The Omnibus Budget Reconciliation Act of 1981 removed this requirement, allowing States to vary their medically needy income standard from one covered group to the next. Under the medically-needy spend-down provision (Section 435.831), persons or families with incomes above their group's medically-needy income standard can deduct certain incurred medical expenses for purposes of determining their countable income. Included in these deductible medical services are: (1) Medicare and other health insurance premiums, deductibles, or coinsurance charges, (2) expenses incurred for medical and remedial services included in the Medicaid State Plan, and (3) expenses incurred for services not included in the State Plan but recognized under State law.

3. State-Only Coverage

In addition to the preceding groups, a State may extend Medicaid coverage to other individuals, but must do so entirely at its own expense, because the Federal government will not provide matching assistance in such cases. These groups are referred to as non-categorically medically-needy or "State-only" eligibles, and include (1) individuals who are receiving (or are eligible for) general assistance under a Statewide program; (2) persons between the ages of 21 and 65 who have "sufficient" income and resources to meet daily needs, but not medical expenses, and who are ineligible for Medicaid under the adult or AFDC categories; and (3) persons with incomes above the Federally-established maximum for medically needy groups. Persons covered fully at State expense need not meet any of the requirements for categorical eligibility. Thus, for example, a young, single male above the age of 21 and living alone could (at State option) receive Medicaid benefits as a State-only eligible.

B. Recipients¹⁹

This section presents data on Medicaid recipients, by maintenance assistance status, eligibility category, and demographic characteristics. Table 4.4 shows the distribution of Medicaid recipients by basis of eligibility and maintenance assistance status. Individuals eligible for Medicaid are classified into two major groups according to their maintenance assistance status. "Cash assistance recipients" are those who receive cash assistance for their basic necessities under public assistance programs. "Medical assistance only" individuals are those who do not receive cash assistance. This group includes both the "medically needy" and "categorically eligible" persons not receiving cash assistance. Within these two groups, those receiving Medicaid services are classified by basis of eligibility. Eligibility groups include (1) 65 years of age and over, (2) blind, (3) permanently and totally disabled, (4) children in families with dependent children under 21 years of age, and (5) adults in families with dependent children under 21 years of age. Some States extend Medicaid coverage to persons not falling into any of the above categories. Such persons are classified as "other Title XIX recipients." State-only eligibles (that is, individuals ineligible for Federal matching assistance and covered solely by State funds) are not included in Table 4.4.

For FY 1980 there were approximately 21.6 million Medicaid recipients.²⁰ Of these, 75.5 percent received cash assistance sometime during that year, while 24.5 percent received medical assistance only. The two largest recipient groups were AFDC-related, with 9.3 million recipients being dependent children under 21 years of age, and 4.8 million being adults in families with dependent children. Aged enrollees formed the third largest

¹⁹Adjustments have been made in recipient counts for Pennsylvania. See *National Annual Medicaid Statistics*, Fiscal Years 1973 through 1979, "Technical Appendix," for a detailed discussion of technical problems and adjustments pertaining to the data reported in this and following sections.

²⁰All figures on Medicaid service recipients and expenditures are taken from "Annual Medicaid Statistics," Division of Medicaid Cost Estimates, Bureau of Data Management and Strategy, Health Care Financing Administration. These data are based on annual reports filed by the States.

FIGURE 4.2
Eligibility Coverage of the Medically Needy, Fiscal Year 1980

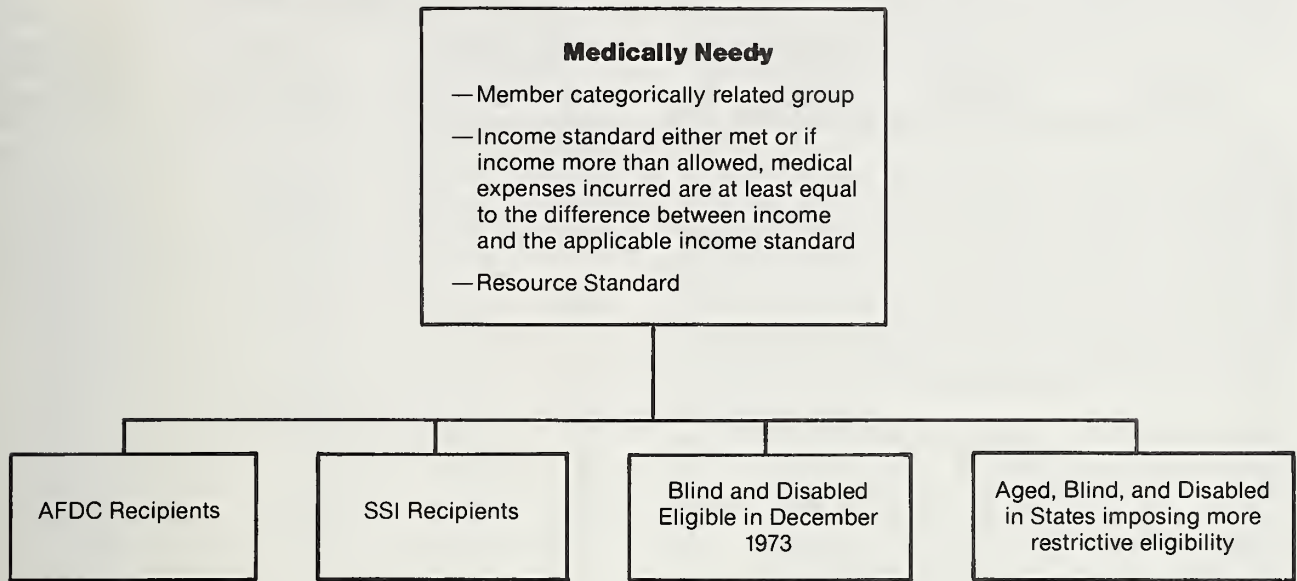


TABLE 4.3

Medicaid Coverage under SSI, by Jurisdiction, February 1982

Medicaid Jurisdiction	All SSI Recipients	More Restricted Standard	Optional Categorically Needy				
			State Supplement Recipients			Individuals Eligible but not Receiving Aid	Individuals Eligible but in Institutions
			Aged	Blind	Disabled		
Alabama	X		X	X	X		X
Alabama	X		X	X	X	X	X
Arkansas	X						X
California	X		X	X	X	X	X
Colorado	X		X			X	X
Connecticut		X	X	X	X	X	
Delaware	X		X	X	X		X
District of Columbia	X					X	X
Florida	X						X
Georgia	X						X
Hawaii		X	X	X	X	X	X
Idaho	X		X	X	X	X	X
Illinois		X	X	X	X		X
Indiana		X	X	X	X		
Iowa	X		X	X	X		X
Kansas	X						
Kentucky	X		X	X	X		
Louisiana	X						X
Maine	X		X	X	X	X	X
Maryland	X		X	X	X	X	X
Massachusetts	X		X	X	X	X	X
Michigan	X		X	X	X		
Minnesota		X	X	X	X		X
Mississippi	X						X
Missouri	X		X	X	X		X
Montana	X		X	X	X	X	X
Nebraska		X	X	X	X		X
Nevada	X		X	X			X
New Hampshire		X	X	X	X	X	X
New Jersey	X		X	X	X	X	X
New Mexico	X						X
New York		X	X	X	X	X	X
North Carolina		X	X	X	X	X	
North Dakota		X				X	X
Ohio		X					X
Oklahoma		X	X	X	X	X	X
Oregon	X		X	X	X	X	X
Pennsylvania	X		X	X	X	X	X
Rhode Island	X		X	X	X	X	X
South Carolina	X		X	X	X		X
South Dakota	X						X
Tennessee	X						
Texas	X						X
Utah		X				X	X
Vermont	X		X	X	X	X	X
Virginia		X	X	X	X	X	X
Washington	X		X	X	X	X	X
West Virginia	X					X	
Wisconsin	X		X	X	X	X	X
Wyoming	X						X

¹ Eligibility determination for the territories is based on separate regulations which are found in 42 CFR 436. The Medicaid agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for OAA, AFDC, AB, APTD, or AABD.

SOURCE: Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982.

TABLE 4.4

Number of Medicaid Recipients by Basis of Eligibility
and Maintenance Assistance Status,
Fiscal Year 1980

Basis of Eligibility	Number of Recipients (thousands)	Percentage Distribution by Maintenance Assistance Status	
		Percent Cash Assistance	Percent Medical Assistance Only
All Eligibility Categories	21,604.4	75.5	24.5
Age 65 and Over	3,416.3	59.9	40.1
Blind	92.3	83.0	17.1
Permanently and Totally Disabled	2,723.5	78.0	22.7
Dependent Children Under 21	9,285.5	86.2	13.8
Adults in Families with Dependent Children	4,774.2	85.3	15.2
Other Title XIX Recipients	1,507.4	0.0	100.0

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

recipient group. Of the 3.4 million recipients in this group, 40.1 percent received "medical assistance only;" in other words, nearly two-fifths of all aged Medicaid recipients were not receiving cash assistance.

Table 4.5 shows the number of Medicaid recipients in each program in FY 1980. Programs are ranked by percent of all recipients; the cumulative percent of national recipients is presented as well. The table also breaks down the number of recipients by eligibility category. Sixty-five percent of all recipients fall into the AFDC category; about 16 percent fall into the 65 years of age and over group. The permanently and totally disabled make up 12.6 percent of all recipients; 7.0 percent are "Other Medicaid" recipients, and 0.4 percent are blind. California had the largest number of recipients in FY 1980—3.4 million or 15.8 percent of the total. Six programs (combined)—California, New York, Puerto Rico, Pennsylvania, Illinois, and Michigan—accounted for almost 50 percent of all Medicaid recipients; (combined) 17 programs accounted for just under 75 percent of all Medicaid recipients.

Table 4.6 shows the age and sex distributions of recipients in each program during FY 1980. Of the 21.6 million recipients in all programs, 50.4 percent were under 21 years of age and 15.5 percent were 65 years of age and over. The percentage of female recipients was almost double that of male recipients, at 64.5 percent compared with 35.5 percent.

C. Service Coverage and Limitations

Title XIX regulations require each Medicaid program to offer a basic set of services to all categorically-needy persons. States receive Federal Financial Participation (FFP) for these basic services, as well as certain optional services they may elect to cover. States may limit the scope of coverage for both required and optional services, but must make service coverage uniform throughout their State.²¹ All States participating in Medicaid must cover the following basic services for all categorically-needy recipients:

1. Inpatient hospital services, other than services in an institution for tuberculosis or mental disease. This category includes items and services ordinarily furnished by the hospital for the care and treatment of inpatients, provided under the direction of a physician or dentist. The hospital must be licensed or formally approved as a hospital by an officially designated State standard-setting authority and either qualified to participate under Medicare or determined to currently meet the requirements of participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid program (Section 440.10).
2. Outpatient hospital services, including preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a hospital outpatient. The hospital must meet the same requirements as for inpatient services: the hospital must be licensed or formally approved as a hospital and must be qualified to participate under Medicare, or must meet the requirements for such participation (Section 440.20).
3. Rural health clinic services (in certified clinics) furnished by a physician or by a physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner (in States where those professionals are not prohibited by State law from furnishing primary health care) (Section 440.20).
4. Other laboratory and X-ray services, including professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner, within the scope of his practice as defined by State law and provided to a patient by, or under the direction of, a physician or other licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. To be eligible for Medicaid cover-

²¹This "Statewideness" rule may be waived for a limited period of time for the purpose of conducting special demonstration studies. OBRA-81 also authorizes waivers of Statewideness under Federally approved section 2176 Home and Community Based Service programs.

TABLE 4.5

Number of Medicaid Recipients by Jurisdiction, by Rank of Jurisdiction, and by Basis of Eligibility,
Fiscal Year 1980

Medicaid Jurisdiction	Number of Recipients (thousands)	Percent of Total	Cumulative Percent of National Total ¹	Percentage Distribution by Basis of Eligibility				
				Age 65 and Over	Blind	Disabled	AFDC	Other Title XIX Recipients
All Jurisdictions	21,604.4	100.0	100.0	15.8	0.4	12.6	65.1	7.0
California	3,417.7	15.8	15.8	16.6	0.7	15.5	62.0	7.2
New York	2,288.1	10.6	26.4	13.7	0.2	10.5	65.5	10.1
Puerto Rico	1,386.1	6.4	32.8	—	(Z)	2.5	50.1	47.3
Pennsylvania	1,250.6	5.8	38.6	10.2	0.3	11.2	73.7	4.6
Illinois	1,048.6	4.9	43.5	7.7	0.1	13.0	78.2	1.0
Michigan	973.4	4.5	48.0	9.7	0.2	11.2	78.1	0.8
Ohio	808.6	3.7	51.7	15.6	0.4	14.2	75.8	—
Massachusetts	774.9	3.6	55.3	19.9	1.0	11.4	59.4	9.5
Texas	687.7	3.2	58.5	35.8	0.6	15.2	52.6	—
New Jersey	676.3	3.1	61.6	9.7	0.2	9.5	78.4	2.2
Florida	500.7	2.3	63.9	23.3	0.5	18.4	57.8	—
Georgia	430.3	2.0	65.9	23.6	0.7	20.7	52.1	0.6
Wisconsin	424.5	1.9	67.8	15.8	0.2	11.1	71.2	1.7
Kentucky	410.2	1.9	69.7	18.0	0.6	15.7	65.8	—
North Carolina	376.7	1.7	71.5	21.2	0.7	14.2	62.5	1.4
Louisiana	365.2	1.7	73.2	27.3	0.5	17.2	53.8	1.3
Tennessee	354.4	1.6	74.9	23.7	0.9	21.9	52.5	0.9
South Carolina	337.3	1.6	76.4	23.2	0.7	18.3	56.2	1.6
Minnesota	325.4	1.5	77.9	16.5	0.2	11.6	65.6	6.0
Alabama	324.4	1.5	79.4	28.3	0.5	17.6	53.6	—
Missouri	321.5	1.5	80.9	21.4	1.0	12.5	64.9	0.2
Virginia	320.4	1.5	82.4	20.3	0.4	14.4	66.7	2.2
Washington	315.2	1.4	83.9	15.4	1.3	12.9	70.3	9.0
Maryland	312.5	1.4	85.3	12.7	0.1	11.0	76.2	—
Mississippi	306.9	1.4	86.7	26.7	0.5	11.0	61.6	0.3

(continued)

TABLE 4.5 (continued)
Number of Medicaid Recipients by Jurisdiction, by Rank of Jurisdiction, and by Basis of Eligibility,
Fiscal Year 1980

Medicaid Jurisdiction	Number of Recipients (thousands)	Percent of Total	Cumulative Percent of National Total ¹	Percentage Distribution by Basis of Eligibility				
				Age 65 and Over	Blind	Disabled	AFDC	Other Title XIX Recipients
Oregon	277.1	1.3	88.0	11.6	0.6	9.4	65.4	12.9
Oklahoma	253.6	1.2	89.2	21.3	0.2	10.0	68.5	(Z)
Arkansas	222.5	1.0	90.2	28.4	0.7	18.2	48.4	6.7
Connecticut	216.6	1.0	91.2	14.7	(Z)	10.0	75.1	0.2
Indiana	205.3	0.9	92.2	16.5	0.4	13.5	69.5	—
Iowa	178.4	0.8	93.0	18.2	0.5	9.7	72.9	3.4
Kansas	149.0	0.7	93.7	15.1	0.2	9.0	61.2	14.5
Maine	145.6	0.7	94.4	15.4	0.2	11.5	71.0	1.8
Colorado	141.3	0.7	95.0	23.3	0.2	12.3	69.0	4.8
West Virginia	129.4	0.6	95.6	15.9	0.3	17.8	67.0	—
Rhode Island	127.8	0.6	96.2	20.0	0.2	9.1	53.8	1.2
District of Columbia	126.7	0.6	96.8	9.1	(Z)	10.7	79.6	0.5
Hawaii	106.6	0.5	97.3	10.6	0.1	6.7	72.6	9.9
New Mexico	87.9	0.4	97.7	13.8	0.5	16.4	67.4	2.0
Nebraska	71.3	0.3	98.0	21.9	0.3	12.6	61.8	3.5
Utah	57.4	0.3	98.3	13.6	0.1	11.1	76.2	6.5
Vermont	53.8	0.2	98.5	16.4	0.2	12.3	73.0	2.0
Delaware	49.2	0.2	98.8	9.5	0.3	10.0	78.5	4.8
Montana	45.8	0.2	99.0	16.2	1.7	13.8	63.5	3.9
New Hampshire	44.9	0.2	99.2	21.2	0.8	10.0	66.3	1.6
Idaho	44.0	0.2	99.4	15.5	0.2	13.2	73.8	2.6
South Dakota	34.9	0.2	99.5	23.6	0.4	12.7	60.7	2.6
North Dakota	31.4	0.1	99.6	25.5	0.1	9.6	57.9	6.2
Nevada	25.2	0.1	99.7	23.8	1.5	16.1	59.3	4.9
Alaska	17.2	0.1	99.8	10.7	0.3	12.6	71.0	5.4
Virgin Islands	13.3	0.1	99.9	9.9	0.1	1.8	70.2	18.1
Wyoming	11.1	0.1	100.0	17.6	0.2	9.9	72.2	—

¹ Total does not sum to 100 percent because of rounding.

² Includes unknown proportion of Other Title XIX recipients that State was unable to identify separately.

“—” Data not available.

(Z) Percentage less than 0.05.

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

TABLE 4.6
Medicaid Recipients, by Jurisdiction, and by Age and Sex of Recipient,
Fiscal Year 1980

Medicaid Jurisdiction	Number of Recipients (thousands)	Percentage Distribution by Age and Sex				
		Age ¹			Sex ¹	
		0-20	21-64	65 +	Male	Female
All Jurisdictions	21,604.4	50.4	34.1	15.5	35.5	64.5
Alabama	324.4	41.7	26.0	32.3	32.6	67.3
Alaska	17.2	—	—	—	—	—
Arkansas	222.5	43.3	26.0	31.0	35.3	64.7
California	3,417.7	45.2	29.5	8.2	36.5	63.4
Colorado	141.3	50.5	28.2	21.3	35.4	64.6
Connecticut	216.6	53.0	30.7	15.1	36.1	64.0
Delaware	49.2	61.6	29.1	9.4	34.5	64.4
District of Columbia	126.7	53.4	37.5	9.1	33.5	66.5
Florida	500.7	45.0	27.2	27.6	33.3	67.0
Georgia	430.3	44.5	28.0	27.0	33.0	63.5
Guam	—	—	—	—	—	—
Hawaii	106.6	—	—	—	—	—
Idaho	44.0	54.1	30.4	15.5	34.6	65.4
Illinois	1,048.6	57.4	32.8	9.9	36.5	63.5
Indiana	205.3	45.3	35.8	18.9	31.0	69.4
Iowa	178.4	52.0	30.0	18.6	35.9	64.1
Kansas	149.0	—	—	—	—	—
Kentucky	410.2	—	—	—	—	—
Louisiana	365.2	—	—	—	—	—
Maine	145.6	52.9	30.8	16.3	38.1	61.9
Maryland	312.5	53.0	33.0	14.0	34.5	65.2
Massachusetts	774.9	47.2	35.9	16.8	32.0	68.0
Michigan	973.4	54.2	35.4	10.4	36.6	63.4
Minnesota	325.4	46.4	35.4	18.2	38.3	61.4
Mississippi	306.9	47.9	25.2	26.8	35.0	65.1
Missouri	321.5	43.1	29.3	24.1	33.5	66.5
Montana	45.8	51.2	30.3	17.6	37.6	61.3
Nebraska	71.3	49.0	29.0	22.5	34.5	64.8
Nevada	25.2	47.7	21.5	23.0	33.5	65.8
New Hampshire	44.9	—	—	—	—	—
New Jersey	676.3	—	—	—	—	—
New Mexico	87.9	46.4	31.2	17.0	35.1	63.2
New York	2,288.1	—	—	—	—	—
North Carolina	376.7	47.3	31.2	21.5	33.7	66.3
North Dakota	31.4	—	—	—	—	—
Ohio	808.6	51.8	32.5	15.7	35.8	64.2
Oklahoma	253.6	51.2	26.1	22.7	35.3	64.7
Oregon	277.1	—	—	—	—	—
Pennsylvania	1,250.6	56.1	33.2	9.9	36.3	63.7
Puerto Rico	1,386.1	46.2	53.8	—	—	—
Rhode Island	127.8	43.0	28.6	28.8	33.7	66.3
South Carolina	337.3	—	—	—	—	—
South Dakota	34.9	—	—	—	—	—
Tennessee	354.4	42.2	30.2	27.6	34.7	64.5
Texas	687.7	40.0	25.2	35.0	34.2	65.8
Utah	57.4	55.7	31.8	12.5	36.5	63.5
Vermont	53.8	50.9	31.3	17.9	37.5	62.5
Virgin Islands	13.3	68.5	21.6	9.9	36.0	64.0
Virginia	320.4	49.7	30.6	19.7	34.8	65.2
Washington	315.2	51.0	35.5	13.5	37.2	62.7
West Virginia	129.4	47.8	35.9	16.3	30.5	63.7
Wisconsin	424.5	48.1	31.1	16.6	37.2	62.7
Wyoming	11.1	—	—	—	—	—

¹ Percentages will not always sum to 100 percent because of unknowns and rounding.

— Data not available.

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

age, services must be provided to a patient by a laboratory that is qualified to participate under Medicare, or is determined to meet the requirements for such participation (Section 440.30).

5. Skilled nursing facility (SNF) services for individuals 21 years of age and over, other than services in an institution for tuberculosis or mental diseases. These services must be ordered by and under the direction of a physician. The facility must be qualified for participation in Medicaid (Section 440.40).
6. Physicians' services, whether provided in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. Physicians' services are defined to include services provided within the scope of practice of the profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy (Section 440.50).
7. Early and periodic screening, diagnosis, and treatment (EPSDT) for recipients under age 21. This includes screening and diagnostic services to determine physical or mental defects as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (Section 440.40).
8. Family planning services and supplies for individuals of child-bearing age who are eligible for Medicaid and desire such services and supplies (Section 440.40).
9. Home health services when provided in the patient's residence by a licensed agency. These include nursing services provided on a part-time or intermittent basis by a home health agency (HHA) or registered nurse (when there is no HHA in the area); home health aide services provided by an HHA and medical supplies, equipment, and appliances suitable for use in the home (Section 440.70).

As of October 1, 1981, States with a medically-needy program must cover the following services for those individuals (Section 440.220): (1) prenatal care and delivery services for pregnant women, (2) ambulatory services for children under 18 years of age and individuals entitled to institutional services, and (3) home health services (Section 440.70) to any individual entitled to SNF services (Section 440.40).

In addition to federally required services, each State may offer coverage for certain "optional" services:

1. Medical or other remedial care provided by licensed practitioners within the scope of practice as defined under State law. These practitioners may include among others, chiropractors (with limitations), optometrists, and podiatrists (Section 440.60).
2. Home health services in addition to those required under Section 440.70. Specifically included are physical therapy, occupational therapy, or speech pathology, and audiology services, provided by an HHA or by a facility licensed by the State to provide medical rehabilitation services (Section 440.70(b)(4)).
3. Private duty nursing services, defined as nursing services provided by a professional registered nurse or a licensed practical nurse, under the general direction of the patient's physician, to a patient in his or her own home or in a hospital or

SNF when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF.

4. Clinic services, that is, preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital, but which is organized and operated to provide medical care to outpatients.
5. Dental services, in addition to those required to be provided to persons under 21 years of age in the State's Early and Periodic Screening, Diagnosis, and Treatment program.
6. Physical therapy and related services, including physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary when rendered by, or under the supervision of, an individual qualified (licensed, registered, or certified, as appropriate) in the practice of the appropriate profession, and under the prescription or referral of a physician.
7. Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses. Prescribed drugs which may be provided are simple or compounded substances or mixtures of substances prescribed by a physician or other licensed practitioner of the healing arts.
8. Other diagnostic, screening, preventive, and rehabilitative services.
9. Inpatient hospital services, SNF services, and ICF services to persons 65 years of age and over in institutions for tuberculosis or mental disease.
10. ICF services, other than services in an institution for TB or mental disease, for the physically ill or mentally retarded.
11. Inpatient psychiatric hospital services for persons under 21 years of age.
12. Other medical or remedial care recognized under State law. Such additional items and services include transportation, emergency hospital services, personal care services (non-professional) prescribed by a physician and performed under the supervision of a registered nurse in the home, Christian Science sanatoria and nursing services, and SNF services for persons under 21 years of age.

Table 4.7 shows the optional services each State offers to the categorically needy and medically needy. More than 90 percent of the 54 States and territories offer prescribed drug services and/or ICF services. Prosthetic devices, clinic services, emergency hospital services, ICF services for the mentally retarded, and SNF services for persons under 21 years of age are offered by at least 80 percent of the States. Most other optional services are offered by at least 40 percent of the States. Exceptions are Christian Science nurses and sanatoria, private duty nursing, personal care services, preventive and screening services, and SNF and ICF services for persons 65 years of age and over in TB institutions.

Once a State has selected a benefit package, Federal regulations require the State plan to specify the amount and/or duration of each item of medical and remedial care and services covered. Such items must be (1) suffi-

cient in amount, duration, and scope to reasonably achieve their purpose (Section 440.230), and (2) comparable across all categorically-needy recipients and within each medically-needy group (Section 440.240). Also, States may not impose limits on the basis of "diagnosis, type of illness, or condition." Within these general guidelines, States are free to set whatever service limits they choose.

Table 4.8 shows the limitations imposed by States on four mandatory and two optional services. Forty-four States (including the District of Columbia) limit inpatient hospital services; 37 States limit outpatient hospital services; 43, physician services; and 35, services in SNF's. Of those services authorized under home health care, 36 States limit part-time nursing services, 35 limit aide services; 42 either limit or do not cover physical, occupational, speech and hearing therapy; and 45 limit medical supplies and equipment. Thirty-one States limit services covered in ICF's, and 27 either do not offer or limit services covered in ICF's for the mentally retarded.

Table 4.9 shows the limitations imposed by States on prescription drugs as of August 1981. Eighteen States impose a fixed or variable copayment on each prescription; 5 limit the number of prescriptions per recipient; and 30 limit the number of refills per prescription. Florida is the only State that imposes a dollar (as opposed to quantity) limit on prescription costs (\$22/month per recipient). Twenty-six States limit the size of each prescription; all but 7 exclude most or all over-the-counter drugs from coverage; and all but 5 employ formulary restrictions of varying stringency.

D. Utilization

This section presents data on the use of medical services by Medicaid recipients. For each program, tables show the distribution of Medicaid recipients by type of medical service; the number of recipients and volume of services received, for general hospitals, SNF's, ICF's, physicians, and drug prescriptions; the number of EPSDT screenings and conditions found; and the number and types of sterilization procedures performed. Recipient counts for each type of service are unduplicated, although the same recipient may have received more than one type of service; for example, the same recipient may have used inpatient hospital services, physicians' services, and outpatient hospital services. Thus, the total number of recipients generally will be less than the sum of recipients receiving each service.

In addition, Medicaid utilization estimates do not include a comparison population ("population at-risk") as do the Medicare rates presented in Chapter 3. Instead, they represent average use by those actually receiving services as opposed to all those eligible to receive such services. (No national counts of Medicaid eligibles (as opposed to recipients) are available at the present time, although work is in progress to develop an unduplicated count of eligibles).

Table 4.10 shows the number of recipients in each program in FY 1980 along with the percentage of all recipients using specific services. Because a recipient can receive more than one service, percentages are expressed as a percent of total recipients.

Table 4.11 breaks down the number of Medicaid recipients in FY 1980 by type of medical service and by recipient's age and sex. Females made up 66.2 percent of all recipients and males 32.2 percent. Recipients under

21 years of age were the most frequent users of dental services, physicians' services, outpatient hospital services, clinic services, and prescribed drugs. Recipients 65 years of age and over were the most frequent users of SNF and ICF services. Family planning services, other care, laboratory and radiological services, other practitioner services, inpatient hospital services, and home health services were used most frequently by the 21-64 age group. More women than men used each type of service.

Table 4.12 shows the number of recipients and total days of care in general hospitals, SNF's and ICF's (other than for mental retardation), along with the number of physician visits and the number of outpatient drugs dispensed to Medicaid recipients. For general hospitals, total discharges are a count of hospital stays, and recipients discharged are an unduplicated count of persons. A day of care in general hospitals, SNF's, or ICF's is counted only if paid for in whole, or in part, by Medicaid. As a result, it is not possible to derive average lengths of stay for Medicaid patients from this data alone.

A physician visit is a consultation with a physician or a person acting under the physician's supervision. When a physician's bill does not show visits but simply a flat fee, the recipient is reported as receiving physicians' services but the number of visits is not reported. The number of prescriptions includes refills, but covers only drugs dispensed outside a hospital or other inpatient facility.

Table 4.13 shows the number of individuals screened under the EPSDT program in FY 1980. Screening is defined as the use of medically-approved procedures to distinguish apparently well persons from persons who may have a disease or abnormality, and to identify persons in need of more definitive study of their physical or mental problems. Of the 1.7 million recipients screened (based on reports received from the States), 46.7 percent were under 6 years of age. While the number of screenings vary widely across the States, it should be noted that these data do not take account of State differences in population.

Table 4.14 shows the number of sterilizations performed in CY 1980.²² Of the 86.6 thousand sterilizations reported, California alone accounted for nearly 15 percent.

E. Expenditures

This section describes the distribution of Medicaid vendor payments, by program, basis of eligibility, type of service, and age, race, and sex of recipient.

Table 4.15 shows the distribution of vendor payments, by aid category and public assistance status—cash assistance or medical assistance only. Cash assistance recipients accounted for 52.6 percent of total vendor payments; medical assistance recipients for 47.4 percent. Except for the "age 65 and over" category, cash assistance recipients accounted for the larger share of vendor payments in each eligibility group.

²²This number underestimates total sterilizations actually performed because some States (for example, New York) did not report sterilizations and other States did not report for all possible methods.

TABLE 4.8
Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	Limitations on Inpatient Hospital Services										
	No Limits	Maximum Days Per Year ¹	Prior Authorization Required		Services and Procedures Not Covered			Services and Procedures Limited			
			All Elective Procedures	Certain Specific Procedures	Elective Surgery	Other Specific Services or Procedures ²	Procedures that Could be on an Out-Patient Basis	Weekend Admissions and/or Pre-operative Days	Dental Procedures	Sterilization Services	Other Limits
Alabama		15		X					X		X
Alaska		21		X							X
Arizona											
Arkansas ³				X					X		X
California			X			X	X				
Colorado											X
Connecticut	X										
Delaware	X			X					X	X	X
District of Columbia						X					
Florida		45					X				
Georgia		25		X			X			X	X
Hawaii ⁴				X							
Idaho ⁵		40						X			
Illinois											
Indiana				X							
Iowa							X	X	X	X	X
Kansas							X				
Kentucky ⁵		14					X	X	X		X
Louisiana				X							X
Maine											
Maryland		20		X			X			X	X
Massachusetts ⁶											
Michigan ³				X			X			X	X
Minnesota											
Mississippi	X	20					X			X	

(continued)

TABLE 4.8 (continued)
Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	No Limits	Maximum Days Per Year ¹	Prior Authorization Required		Limitations on Inpatient Hospital Services			Services and Procedures Limited			
			All Elective Procedures	Certain Specific Procedures	Elective Surgery	Other Specific Services or Procedures ²	Procedures that Could be on an Out-Patient Basis	Weekend Admissions and/or Pre-operative Days	Dental Procedures	Sterilization Services	Other Limits
Missouri						X				X	X
Montana	X										
Nebraska											X
Nevada											X
New Hampshire		12									
New Jersey						X		X			X
New Mexico											X
New York ¹⁰							X	X			X
North Carolina				X		X					X
North Dakota	X										X
Ohio ⁷		60				X				X	X
Oklahoma ⁸		10									
Oregon		18									
Pennsylvania				X		X	X		X	X	
Puerto Rico											
Rhode Island						X	X	X		X	X
South Carolina		12				X				X	
South Dakota		30		X		X				X	
Tennessee		14		X		X	X	X	X	X	X
Texas ⁷		30				X					
Utah			X								
Vermont										X	
Virgin Island				X		X			X		
Virginia ⁹											
Washington ¹⁰		14	X			X		X	X		X
West Virginia											
Wisconsin		20		X							X
Wyoming						X					X

(See footnotes at end of table.)

TABLE 4.8 (continued)
 Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	Limitations on Outpatient Hospital Services										Limitations on Skilled Nursing Facilities				
	No Limits	Limited Number of Visits Per Year	Limited to Services Ordered by Physicians in Emergencies	Specific Procedure/ Special Services		Services/Procedures Limited		Prior Authorization Required (Specific Services)	Other Limits	No Limits	Prior Authorization Required	Periodic Re-authorization Required	Other Limits		
				Not Covered	Psychiatric Services	Sterilization Services									
Alabama		6						X			X				
Alaska	X										X				
Arkansas		12						X			X				
California				X				X	X		X	X			
Colorado				X							X	X			
Connecticut															
Delaware	X							X		X					
District of Columbia									X	X			X		
Florida								X	X	X					
Georgia				X							X				
Hawaii															
Idaho		6			X				X	X	X				
Illinois	X								X	X					
Indiana								X			X		X		
Iowa			X				X		X						
Kansas									X	X					
Kentucky			X						X			X			
Louisiana		3							X	X			X		
Maine	X								X				X		
Maryland				X	X		X	X	X		X		X		
Massachusetts ¹⁹	X												X		
Michigan					X	X	X	X	X		X	X			
Minnesota	X			X						X					
Mississippi		12							X	X	X				
Missouri		24						X	X	X	X	X			

(continued)

TABLE 4.8 (continued)
 Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

Limitations on Outpatient Hospital Services														
State	No Limits	Limited Number of Visits Per Year	Limited to Services Ordered by Physicians in Emergencies	Specific Procedure/ Special Services Not Covered	Services/Procedures Limited		Prior Authorization Required (Specific Services)	Other Limits	Limitations on Skilled Nursing Facilities					
					Psychiatric Services	Sterilization Services			No Limits	Prior Authorization Required	Periodic Re-authorization Required	Other Limits		
Montana	X							X						
Nebraska				X				X						
Nevada								X						
New Hampshire		12		X				X					X	
New Jersey													X	
New Mexico								X						
New York	X										X			
North Carolina		24		X				X			X			X
North Dakota	X									X				
Ohio		48						X						X
Oklahoma			X											X
Oregon														X
Pennsylvania		36						X						X
Rhode Island						X		X			X			X
South Carolina		18									X			
South Dakota	X							X						
Tennessee		30												X
Texas				X				X						X
Utah								X			X			
Vermont			X											X
Virginia														
Washington				X				X					X	
West Virginia													X	
Wisconsin								X						
Wyoming				X						X				X

(See source at end of table.)

TABLE 4.8 (continued)
 Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

Limitations on Physicians' Services													
State	Maximum Visits per Year												
	Procedure-Specific Limits						Setting-Specific Limits						
	No Limits	Psychiatric	Consultation	Family Planning	Comprehensive Care	Hyposensitization	Eye	Inpatient Hospital (per day)	Office	Home	Long-Term Care Facility	Emergency Room	Other Settings
Alabama ¹¹	X							1					12
Alaska	X												
Arkansas	X		2					2					12
California		24				24							
Colorado	X												
Connecticut	X												
Delaware	X												
District of Columbia	X												
Florida ¹³			1					1			12		
Georgia				2				1	12				
Hawaii	X												
Idaho	X										24		
Illinois	X												
Indiana	X												
Iowa	X												
Kansas													
Kentucky		4			1								
Louisiana	X							1	12				12
Maine	X												
Maryland	X												
Massachusetts	X												
Michigan	X										12		
Minnesota	X												
Mississippi	X							1			36		12
Missouri	X				1							24	

(continued)

TABLE 4.8 (continued)
Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

Limitations on Physicians' Services													
State	Maximum Visits per Year												
	Procedure-Specific Limits						Setting-Specific Limits						
	No Limits	Psychiatric	Consultation	Family Planning	Comprehensive Care	Hyposensitization	Eye	Inpatient Hospital (per day)	Office	Home	Long-Term Care Facility	Emergency Room	Other Settings
Montana							1						
Nebraska	X								24				
Nevada	X												
New Hampshire ¹²	X												12
New Jersey	X												
New Mexico								2					
New York	X												
North Carolina	X												18
North Dakota	X												
Ohio	X												
Oklahoma ¹³	X							1	48	48	24		
Oregon						1							
Pennsylvania ^{11,14}													
Rhode Island ^{15,16,17}	X								18		12		
South Carolina			3										
South Dakota	X												
Tennessee	X												
Texas	X						2	14	24	24	24		
Utah	X												
Vermont ¹⁸											12		
Virginia		26											
Washington											24		
West Virginia	X										12		
Wisconsin	X												
Wyoming					1						12		

(See footnotes at end of table.)

Table 4.8 (continued)

Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	Limitations on Physicians' Services				Limits or Prior Authorization Required for Psychiatric Services
	Prior Authorization Required for:				
	Certain Specific Procedures	Care Outside State	Elective Procedures	Specific Settings	
Alabama	X				
Alaska			X		
Arkansas			X		
California	X		X		X
Colorado					
Connecticut	X				X
Delaware					
District of Columbia	X		X		X
Florida			X		
Georgia	X		X	X	
Hawaii					
Idaho		X			X
Illinois					
Indiana	X				
Iowa	X				
Kansas	X				X
Kentucky					X
Louisiana					
Maine	X	X			
Maryland	X				
Massachusetts	X	X	X		
Michigan	X	X			X
Minnesota	X	X	X		X
Mississippi					
Missouri	X	X	X		X

(continued)

Table 4.8 (continued)

Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	Limitations on Physicians' Services				Limits or Prior Authorization Required for Psychiatric Services
	Prior Authorization Required for:				
	Certain Specific Procedures	Care Outside State	Elective Procedures	Specific Settings	
Montana	X				
Nebraska					
Nevada					
New Hampshire				X	
New Jersey	X				X
New Mexico					
New York					
North Carolina	X	X			X
North Dakota					
Ohio				X	
Oklahoma					
Oregon		X	X		
Pennsylvania					
Rhode Island	X	X	X	X	X
South Carolina					
South Dakota					
Tennessee	X		X		
Texas					
Utah	X		X		
Vermont	X		X		X
Virginia	X				X
Washington			X		X
West Virginia	X	X			X
Wisconsin		X			
Wyoming					

(See source at end of table.)

Table 4.8 (continued)
 Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	Part-Time Nursing						Aide Services				
	No Limits	Prior Authorization	Visit Limits	Physician Oversight Required	Other Limits	Not Provided	No Limits	Prior Authorization	Visit/ Hour Limits	Physician Oversight Required	Other Limits
Alabama		X	X					X	X		
Alaska				X						X	
Arkansas				X	X					X	X
California		X	X					X	X		
Colorado		X						X			X
Connecticut			X					X	X		
Delaware	X						X				
District of Columbia	X						X				
Florida	X						X				
Georgia			X	X					X	X	
Hawaii	X						X				
Idaho		X						X	X		
Illinois		X						X			
Indiana		X	X		X	X					
Iowa	X						X				
Kansas					X		X			X	
Kentucky					X		X				
Louisiana			X		X		X		X	X	X
Maine	X		X				X				
Maryland		X	X					X	X		
Massachusetts	X				X			X			
Michigan				X	X					X	X
Minnesota	X						X				
Mississippi			X						X		
Missouri			X	X	X				X	X	X

(continued)

Table 4.8 (continued)
Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

Limitations on Home Health Services											
State	Part-Time Nursing					Aide Services					
	No Limits	Prior Authorization	Visit Limits	Physician Oversight Required	Other Limits	Not Provided	No Limits	Prior Authorization	Visit/ Hour Limits	Physician Oversight Required	Other Limits
Montana			X						X		X
Nebraska	X										
Nevada		X						X			
New Hampshire			X					X	X		
New Jersey		X		X							
New Mexico					X						X
New York	X							X			
North Carolina					X						X
North Dakota	X						X				
Ohio				X	X					X	X
Oklahoma			X						X		
Oregon		X						X			
Pennsylvania			X	X					X	X	
Rhode Island		X	X					X	X		
South Carolina			X		X	X				X	
South Dakota			X						X	X	
Tennessee			X	X	X				X		X
Texas		X	X	X				X		X	
Utah	X						X				
Vermont				X							X
Virginia	X										
Washington				X	X					X	
West Virginia	X						X				X
Wisconsin	X						X				
Wyoming					X		X				

(See source at end of table.)

TABLE 4.8 (continued)
 Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

Limitations on Home Health Services													
State	Physician and Occupational Therapy/Speech-Hearing						Medical Supplies/Equipment						
	Not Provided	No Limits	Prior Authorization	Visit Limits	Service Limits	Physician Oversight Required	Other Limits	No Limits	Prior Authorization	Quantity or Dollar Limits	Restricted Supply List	Physician Prescription Required	Other Limits
Alabama	X										X	X	
Alaska						X			X				
Arkansas						X						X	
California			X			X			X			X	
Colorado			X						X				
Connecticut			X						X			X	
Delaware		X						X					
District of Columbia							X				X		
Florida	X								X	X	X	X	
Georgia			X	X			X		X		X		
Hawaii		X						X					X
Idaho					X				X	X			
Illinois			X						X				
Indiana			X						X				
Iowa					X		X				X		
Kansas							X		X				X
Kentucky					X	X			X			X	
Louisiana					X	X	X		X			X	
Maine									X				
Maryland		X			X		X					X	X
Massachusetts													
Michigan					X		X					X	X
Minnesota					X	X							X
Mississippi				X	X					X			
Missouri					X	X			X	X	X	X	X

(continued)

TABLE 4.8 (continued)
Limitations on Selected Medicaid Services, by Jurisdiction, April 1982
Limitations on Home Health Services

State	Physician and Occupational Therapy/Speech-Hearing							Medical Supplies/Equipment					
	Not Provided	No Limits	Prior Authorization	Visit Limits	Service Limits	Physician Oversight Required	Other Limits	No Limits	Prior Authorization	Quantity or Dollar Limits	Restricted Supply List	Physician Prescription Required	Other Limits
Montana				X	X				X				X
Nebraska		X							X	X			
Nevada			X	X	X				X	X		X	
New Hampshire													
New Jersey			X			X			X			X	
New Mexico							X		X				
New York		X							X				
North Carolina					X				X				X
North Dakota		X						X					
Ohio			X	X	X							X	X
Oklahoma	X												
Oregon			X		X					X			
Pennsylvania						X	X		X				
Rhode Island			X	X			X		X				
South Carolina					X		X						
South Dakota				X		X	X						X
Tennessee				X	X		X	X	X		X	X	X
Texas	X								X			X	X
Utah			X		X				X			X	X
Vermont							X						
Virginia						X			X		X		
Washington					X		X						
West Virginia		X							X				X
Wisconsin			X	X	X								X
Wyoming							X						X

(See source at end of table.)

TABLE 4.8 (continued)

Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	Limitations on Selected Optional Long-Term Care Services									
	Services in Intermediate Care Facilities					Services in Intermediate Care Facilities for the Mentally Retarded				
	Not Provided	No Limits	Prior Authorization	Periodic Reauthorization	Other Limits	Not Provided	No Limits	Prior Authorization	Periodic Reauthorization	Other Limits
Alabama			X					X		
Alaska			X					X		
Arkansas			X					X		
California			X	X				X	X	
Colorado			X	X				X		
Connecticut			X	X				X		
Delaware		X					X			
District of Columbia		X					X			
Florida		X					X			
Georgia			X					X		
Hawaii			X					X		
Idaho					X					X
Illinois		X			X		X			X
Indiana										
Iowa		X					X			
Kansas					X					X
Kentucky			X	X				X	X	
Louisiana		X					X			
Maine		X			X		X			
Maryland			X		X		X			
Massachusetts ¹⁹					X		X			
Michigan			X	X				X	X	
Minnesota		X					X			
Mississippi			X	X				X	X	
Missouri			X					X		
Montana		X					X			
Nebraska					X					X
Nevada			X					X		
New Hampshire			X	X				X	X	
New Jersey			X					X		

(continued)

TABLE 4.8 (continued)

Limitations on Selected Medicaid Services, by Jurisdiction, April 1982

State	Limitations on Selected Optional Long-Term Care Services									
	Services in Intermediate Care Facilities					Services in Intermediate Care Facilities for the Mentally Retarded				
	Not Provided	No Limits	Prior Authorization	Periodic Reauthorization	Other Limits	Not Provided	No Limits	Prior Authorization	Periodic Reauthorization	Other Limits
New Mexico		X					X			
New York			X				X			
North Carolina			X					X		
North Dakota		X					X			
Ohio					X					X
Oklahoma										
Oregon			X		X			X		
Pennsylvania					X		X	X		
Rhode Island			X	X				X		
South Carolina			X					X		
South Dakota	X									X
Tennessee					X		X			
Texas					X					X
Utah	X						X			
Vermont					X		X			
Virginia	X						X			
Washington			X	X				X	X	
West Virginia					X					X
Wisconsin			X		X			X		X
Wyoming	X					X				

¹ Many States with limits on the number of days have administrative procedures to exempt individual cases from the limit.² Most frequently, cosmetic procedures, non-coverage of private rooms, private nurses, etc.³ Based on average length of stay by diagnosis.⁴ Eight-day limit on medical and surgical admissions.⁵ Days per admission.⁶ Based on level-of-care guidelines.⁷ Days per episode.⁸ Days per admission with 20 days between date of discharge and date of readmission.⁹ Extended to 21 days if appropriately certified.¹⁰ Determined by PSRO.¹¹ Limited to one year for children and one every 2 years for adults.¹² Limited to 12 inpatient hospital services per year including those of licensed inpatient psychiatrists and ophthalmologists.¹³ Included in office visits.¹⁴ Limited to two per year for recipients under age 21 and one every two years for recipients age 21 and over.¹⁵ Limited to maximum of three family members treated on 1 day.¹⁶ Limited to total of 37 visits.¹⁷ Limited to maximum of six patients in long-term care facility treated on same day.¹⁸ Limited to \$500.00 per calendar year.¹⁹ For skilled nursing facility and intermediate care facility services, prior authorization is required for out-of-State placements, and for pediatric and psychiatric admissions.

SOURCE: Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982.

TABLE 4.9

Drug Program Characteristics and Service Limits on Prescribed Drugs, August 1981

State	Type of Copayment ¹	Copayment Level	Maximum Prescriptions Per Recipient (per month)	Maximum Number of Refills (per time period)	Maximum Quantity (in days)	Over the Counter Exclusions ²	Formulary States
Alabama	V	\$0.50-\$3.00		5 (6 mos.)	34	B	C
Alaska					33		
Arkansas			4				
Arizona	F	1.00	4	5 (6 mos.)		B	B
California		1.00			100	B	C
Colorado				Variable Minimums		B	C
Connecticut				0	30-90	B	B
Delaware						B	B
District of Columbia	V	0.50		3 (4 mos.) 5		B	C
Florida						B	B
Georgia	V	0.50-3.00				B	C
Hawaii						A	B
Idaho	F	0.50			34	B	B
Illinois				2 (3 mos.)	30	B	C
Indiana						A	A
Iowa	F	0.50			30-90	B	B
Kansas	F	0.50		5	30-100	A	A
Kentucky				5 (6 mos.)		B	D
Louisiana				5 (6 mos.)	30	B	B
Maine				5	180	B	B
Maryland	F	0.50		2	100	B	B
Massachusetts				5 (6 mos.)	180		B
Michigan	F	0.50 ⁶		3 (4 mos.)		B	C
Minnesota				5 (6 mos.)	30-100	A	A
Mississippi	F	0.50	6	3	N/A	B	D
Missouri	V	0.50-1.00	5		34-90		C
Montana	F	0.50				B	B
Nebraska					N/A	B	C
Nevada	V	0.50-3.00	3		30-100	B	B
New Hampshire		1.00		5 (6 mos.)	30-90	A	B
New Jersey				5 (6 mos.)	60	A	B
New Mexico	F	0.25		3 (3 mos.)	180	B	C
New York				5 (6 mos.)		B	C
North Carolina	F	0.50	6			B	B
North Dakota				5 (12 mos.)		A	B
Ohio				5 (6 mos.)	34	B	C
Oklahoma			3	5 (per Prescription)	34	B	C
Oregon				5 (6 mos.)	100	C	A

(continued)

TABLE 4.9 (continued)

Drug Program Characteristics and Service Limits on Prescribed Drugs, August 1981

State	Type of Copayment ¹	Copayment Level	Maximum Prescriptions Per Recipient (per month)	Maximum Number of Refills (per time period)	Maximum Quantity (in days)	Over the Counter Exclusions ²	Formulary States
Pennsylvania				5 (6 mos.)	34	A	B
Rhode Island				5	30-90	B	B
South Carolina	F	0.50		5 (6 mos.)		B	C
South Dakota	F	1.00				B	B
Tennessee			7	5 (6 mos.)	30	B	D
Texas			3	5 (6 mos.)		A	C
Utah				N/A	30-100	B	
Vermont		1.00		5	60	B	A
Virginia	F	0.50			30	B	B
Washington				N/A	N/A		C
West Virginia	V	0.50-1.00		5	30	B	C
Wisconsin					34	B	C
Wyoming ⁴							

Note: An empty data cell indicates that no limit is known to exist.

"—" Indicates that a limit is in effect but specific information was unavailable.

¹ Type of copayment:

F — Fixed copayment on each Rx

V — Variable copayment on each Rx

A blank space indicates that the State has no copayment requirement.

² OTC Exclusion codes: A — All or most OTC drugs reimbursable.

B — Few or no OTC drugs reimbursable except insulin.

³ Formulary Status: A — No drug list. All legend drugs reimbursable.

B — No drug list, but certain categories excluded from reimbursement.

C — Limited drug list.

D — Restricted drug list.

⁴ Alaska and Wyoming have no drug program.

⁵ No limit is prescribed within 12 months of original prescription date.

⁶ Copayment applied to high cost, multi-source drugs only.

SOURCE: National Pharmaceutical Council, Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982.

TABLE 4.10

Number of Medicaid Recipients and Proportion Using Specific Services, by Type of Medical Service and Jurisdiction, Fiscal Year 1980

Percent of Total Recipients Using Specific Services ¹												
Medicaid Jurisdiction	Number of Recipients (thousands)	Inpatient Hospital Services		Skilled Nursing Facility Service	Intermediate Care Facility Services			Physicians' Services	Dental Services	Other Practitioners' Services	Outpatient Hospital Services	Clinic Services
		General Hospital	Mental Hospital		Mentally Retarded	All Other						
All Jurisdictions	21,604.4	17.3	0.3	2.8	0.6	3.7	63.7	21.5	14.7	44.3	7.3	
Alabama	324.4	22.4	(Z)	2.9	—	4.4	74.1	13.1	0.7	34.2	—	
Alaska	17.2	12.6	0.9	2.0	1.2	5.0	63.0	20.5	23.1	27.9	2.5	
Arkansas	222.5	21.7	(Z)	2.9	0.9	6.8	73.2	19.3	12.2	36.2	3.3	
California	3,417.7	15.1	0.1	3.8	—	0.3	72.5	27.8	21.0	40.7	5.0	
Colorado	141.3	17.6	0.4	3.9	1.2	7.3	56.9	16.3	21.3	49.9	35.6	
Connecticut	216.6	16.7	1.0	10.1	(Z)	2.0	67.5	26.5	25.7	51.8	12.6	
Delaware	49.2	16.3	0.1	0.2	0.9	2.8	75.0	8.9	7.0	50.5	7.4	
District of Columbia	126.7	17.8	—	0.8	0.4	5.0	60.4	12.1	20.3	52.9	5.9	
Florida	500.7	19.3	0.1	3.0	0.2	3.9	71.1	11.9	5.1	43.4	—	
Georgia	430.3	21.9	—	3.4	0.4	4.6	70.9	18.6	7.4	44.2	4.1	
Hawaii	106.6	12.6	—	2.2	—	1.6	81.2	38.7	8.5	30.0	—	
Idaho	43.9	15.4	—	4.4	1.0	5.7	68.5	20.3	3.9	38.6	1.9	
Illinois	1,048.6	19.6	0.7	2.2	—	5.3	76.7	29.7	25.4	35.7	17.3	
Indiana	205.3	23.8	(Z)	3.9	0.9	11.8	43.7	12.2	6.5	26.8	1.6	
Iowa	178.4	16.5	0.2	1.4	0.9	11.6	78.4	35.2	24.2	37.9	2.5	
Kansas	149.0	21.8	0.7	0.8	2.4	9.8	57.1	25.8	17.6	39.2	4.3	
Kentucky	410.2	17.0	0.1	1.7	0.2	3.5	72.4	20.0	5.4	36.3	7.5	
Louisiana	365.2	47.4	0.1	0.3	1.0	6.8	67.4	10.8	1.9	1.1	11.3	
Maine	145.6	11.7	—	0.4	—	5.6	62.2	22.7	15.5	41.1	3.9	
Maryland	312.5	17.9	—	0.2	—	5.0	74.1	25.5	18.2	57.5	—	
Massachusetts	774.9	24.2	0.3	2.9	0.4	2.8	63.9	38.4	20.3	41.9	12.4	
Michigan	973.4	15.7	0.7	2.7	0.6	3.3	80.0	23.0	15.6	42.5	2.7	
Minnesota	325.4	18.3	0.4	7.5	3.9	7.0	74.0	37.1	18.9	36.4	2.8	
Mississippi	306.9	21.8	—	2.9	0.3	1.9	83.0	21.1	4.6	37.6	(Z)	
Missouri	321.5	21.0	(Z)	0.5	0.7	6.1	58.5	28.0	14.9	45.3	22.6	
Montana	45.8	20.1	(Z)	1.2	0.6	11.0	81.6	30.9	24.6	36.4	2.4	
Nebraska	71.3	21.2	0.4	1.6	1.4	13.1	70.3	27.2	25.3	36.6	24.3	
Nevada	25.2	29.4	(Z)	2.4	0.8	9.4	72.6	17.8	11.0	37.3	0.6	
New Hampshire	44.9	17.7	(Z)	1.2	0.7	10.7	80.6	22.5	21.4	44.6	6.8	
New Jersey	676.3	15.7	0.5	0.5	0.7	3.9	75.4	30.5	19.1	43.9	4.7	
New Mexico	87.9	19.6	—	0.2	0.6	3.6	73.6	24.4	4.8	38.5	10.4	
New York	2,288.1	12.8	1.0	4.0	0.7	3.3	51.2	19.5	12.2	52.5	7.9	

(continued)

TABLE 4.10 (continued)
Number of Medicaid Recipients and Proportion Using Specific Services, by Type of Medical Service and Jurisdiction,
Fiscal Year 1980

Medicaid Jurisdiction	Number of Recipients (thousands)	Percent of Total Recipients Using Specific Services ¹									
		Inpatient Hospital Services		Intermediate Care Facility Services			Physicians' Services	Dental Services	Other Practitioners' Services	Outpatient Hospital Services	Clinic Services
		General Hospital	Mental Hospital	Skilled Nursing Facility Service	Mentally Retarded	All Other					
North Carolina	376.7	20.9	0.3	3.3	0.5	3.4	69.0	25.0	13.0	43.8	8.7
North Dakota	31.4	19.7	0.6	10.9	—	6.1	61.0	32.9	20.7	21.1	0.3
Ohio	808.6	15.8	0.2	4.6	0.5	2.9	65.1	23.5	20.4	50.3	8.2
Oklahoma	253.6	19.8	0.1	(Z)	0.7	9.0	58.2	11.2	4.4	5.6	—
Oregon	277.1	8.5	0.4	0.6	1.5	6.5	68.0	20.2	4.6	28.6	—
Pennsylvania	1,250.6	22.9	—	2.5	0.8	1.4	59.6	19.9	18.4	43.6	11.7
Puerto Rico	1,386.1	4.1	—	@	*	*	99.5	4.0	—	99.4	—
Rhode Island	127.8	14.9	0.2	0.2	0.8	5.6	62.2	24.3	18.7	39.8	—
South Carolina	337.3	17.4	0.6	3.6	0.6	3.8	72.5	12.9	7.1	36.9	—
South Dakota	34.9	22.9	—	2.5	2.3	13.3	78.1	13.8	11.0	29.9	2.6
Tennessee	354.4	28.4	0.5	1.4	0.7	6.3	68.8	12.1	4.1	31.2	11.0
Texas	687.7	24.9	—	1.6	1.7	12.1	81.3	7.0	20.8	31.6	2.5
Utah	57.4	16.2	0.3	3.0	2.3	6.6	78.8	10.3	13.9	38.0	3.2
Vermont	53.8	16.4	0.4	0.6	0.9	5.6	74.4	23.6	16.9	45.0	2.1
Virgin Islands	13.3	6.7	—	—	*	*	1.2	4.1	—	79.5	—
Virginia	320.4	19.3	(Z)	0.9	1.5	5.2	77.2	17.5	0.9	44.7	11.3
Washington	315.2	20.7	0.2	6.8	0.2	0.6	77.8	32.9	21.6	32.4	2.2
West Virginia	129.4	10.9	—	0.2	—	—	61.6	14.2	7.7	25.2	5.6
Wisconsin	424.5	12.0	0.3	10.1	0.6	5.9	52.8	40.8	29.8	36.1	41.2
Wyoming	11.1	19.4	—	4.7	—	5.5	84.9	12.1	7.4	30.8	—

¹ The same recipient may appear in more than one column. Therefore, proportions across services are greater than 100 percent.
"—" Data not available.

(Z) Indicates a percentage less than 0.05.

* Services not provided.

@ Skilled nursing facility services provided in public facilities; no Federal financial participation claimed.

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

TABLE 4.11
Distribution of Medicaid Recipients, by Type of Medical Service, Age, and Sex,
Fiscal Year 1980¹

Type of Services	Number of Recipients (thousands)	Percent Distribution by Age and Sex							
		Age ²					Sex ²		
		Under 6	6-20	21-64	65 +	Unknown	Male	Female	Unknown
Total	21,604.4	15.1	28.4	34.7	16.7	4.8	32.2	66.2	1.5
Inpatient Hospital Services ³	3,737.7	13.2	19.3	39.4	23.2	4.9	30.1	68.9	1.0
Skilled Nursing Facility Services	608.6	0.6	1.0	12.3	71.6	14.3	28.7	69.6	1.7
Intermediate Care Facility Services ⁴	788.6	0.5	1.0	15.1	80.4	3.0	29.5	66.5	3.7
Physicians' Services	13,762.4	18.5	28.9	32.0	15.4	5.2	33.8	64.5	1.7
Dental Services	4,652.7	10.9	52.4	29.9	5.0	1.8	36.2	62.4	1.4
Other Practitioners' Services	3,175.5	6.0	32.5	36.4	18.3	6.8	30.5	68.7	0.8
Outpatient Hospital Services	9,577.5	19.8	29.6	38.1	9.2	3.2	35.5	63.4	1.1
Clinic Services	1,577.0	23.3	32.5	36.7	6.0	1.5	35.5	64.3	0.2
Laboratory and Radiological Services	3,399.7	10.3	26.1	41.9	13.0	8.8	25.1	71.4	3.5
Home Health Services	393.6	11.4	12.8	39.1	35.4	1.3	32.2	67.4	0.4
Prescribed Drugs	13,765.7	16.9	25.2	33.1	19.6	5.2	31.9	66.6	1.5
Family Planning Services	1,127.6	0.0	32.0	64.6	0.3	3.0	1.9	95.6	2.0
Other Care	2,464.4	6.6	19.2	35.0	33.0	6.2	32.1	66.9	1.0

¹ Some States do not report the age and sex of all recipients. Thus the distribution by type of medical service for total jurisdictions will not necessarily be the same as that found on Table 4.6 (Medicaid Recipients by Jurisdiction, and by Age and Sex of Recipient).

² May not sum to 100 percent because of rounding.

³ Excludes recipients in mental hospitals.

⁴ Excludes recipients in institutions for mentally retarded.

SOURCE: Office of Research and Demonstrations, HCFA, unpublished data. These data were taken from Annual reports filed by the States.

TABLE 4.12

Use of General Hospitals, SNF's, ICF's, Physicians, and Drug Prescriptions under Medicaid, by Jurisdiction, Fiscal Year 1980¹

Medicaid Jurisdiction	General Hospitals			SNF's		ICF's (other than MR)		Physicians		Drug Prescriptions	
	Total Discharges	Recipients Discharged	Total Days of Care	Total Recipients	Total Days of Care	Total Recipients	Total Days of Care	Total Visits	Number of Prescriptions		
All Jurisdictions	3,970,895	3,685,116	29,562,602	611,479	101,480,241	788,916	159,223,361	81,365,741	169,457,151		
Alabama	95,092	72,750	403,020	9,528	1,679,760	14,216	175,561	1,284,262	2,922,035		
Alaska	—	2,160	—	340	—	858	—	—	—		
Arkansas	69,708	48,371	415,300	6,484	1,312,453	15,205	3,925,055	12,112,593	1,807,991		
California	626,232	514,540	3,887,940	129,460	23,266,100	9,500	1,272,160	6,348,680	22,052,900		
Colorado	39,346	24,933	329,356	5,575	6,881,425	10,279	19,718,425	82,002	1,313,632		
Connecticut	52,277	36,234	375,987	21,975	4,913,949	4,038	921,657	1,003,450	2,211,783		
Delaware	9,726	8,039	49,292	122	12,609	1,398	370,740	4,705,518	286,569		
District of Columbia	61,359	22,516	682,492	1,025	213,607	6,382	275,690	869,977	803,882		
Florida	133,610	96,666	846,917	15,085	2,157,707	19,420	3,409,082	354,748	5,529,094		
Georgia	136,940	869,077	—	14,709	4,374,122	19,671	7,407,240	997,012	6,454,099		
Guam	—	—	—	—	—	—	—	—	—		
Hawaii	—	13,430	—	2,360	—	1,676	—	—	—		
Idaho	7,184	6,769	28,494	1,936	350,951	2,486	608,152	176,616	332,590		
Illinois	287,943	205,456	2,385,084	23,515	4,560,948	55,596	14,214,066	4,330,364	14,864,800		
Indiana	71,444	48,835	378,660	8,068	1,427,697	24,304	593,696	313,729	4,505,921		
Iowa	32,338	29,424	175,926	2,523	35,139	20,772	6,180,128	590,198	1,755,306		
Kansas	41,476	32,544	265,514	1,132	121,823	14,524	4,471,696	657,778	1,676,882		
Kentucky	75,576	69,584	407,645	7,009	593,859	14,535	3,650,264	2,254,181	2,971,832		
Louisiana	127,542	98,618	371,834	1,055	158,718	24,863	1,005,895	1,373,709	5,085,916		
Maine	21,596	17,070	126,991	628	52,738	8,101	2,510,241	340,924	347,347		
Maryland	73,853	56,077	558,327	528	—	15,776	4,296,775	812,148	2,139,635		
Massachusetts	—	185,268	4,423,279	22,534	5,171,549	21,217	5,760,950	3,017,944	4,780,878		
Michigan	—	153,118	—	26,927	—	31,966	—	—	9,959,886		
Minnesota	83,956	59,649	579,205	24,338	5,557,718	22,703	—	2,053,840	2,487,498		
Mississippi	90,019	66,997	475,445	8,784	2,314,992	5,975	1,468,573	9,397,265	3,779,706		
Missouri	108,319	66,903	440,213	1,761	132,447	19,532	4,695,700	2,048,646	3,904,337		
Montana	10,735	9,222	60,086	564	82,484	4,887	1,221,630	332,767	528,141		
Nebraska	22,075	15,143	125,154	1,168	201,570	9,337	2,502,739	487,892	947,289		
Nevada	10,408	7,413	71,875	596	28,824	2,377	571,851	120,446	193,159		
New Hampshire	10,761	7,948	73,743	545	74,197	4,803	1,381,835	272,091	252,512		
New Jersey	128,493	103,646	1,041,055	4,908	432,277	26,531	—	3,904,640	6,466,926		
New Mexico	17,733	17,219	75,185	169	23,449	3,205	707,850	333,655	592,303		
New York	—	295,161	—	80,083	—	75,506	—	—	—		
North Carolina	101,697	77,042	887,266	12,844	1,782,272	12,640	3,145,043	747,324	4,194,882		
North Dakota	10,905	6,193	54,838	3,412	641,629	1,925	543,869	154,774	355,747		
Ohio	143,933	127,548	945,044	37,590	8,232,060	23,639	5,381,035	2,008,887	6,810,123		

(continued)

TABLE 4.12 (continued)

Use of General Hospitals, SNF's, ICF's, Physicians, and Drug Prescriptions under Medicaid, by Jurisdiction,
Fiscal Year 1980¹

Medicaid Jurisdiction	General Hospitals			SNF's		ICF's (other than MR)		Physicians		Drug Prescriptions
	Total Discharges	Recipients Discharged	Total Days of Care	Total Recipients	Total Days of Care	Total Recipients	Total Days of Care	Total Visits	Number of Prescriptions	
Oklahoma	81,090	50,257	363,569	11	2,958	22,669	5,807,190	661,387	870,713	
Oregon	28,298	23,638	121,885	1,733	135,735	18,117	2,515,120	1,158,777	2,212,148	
Pennsylvania	412,726	286,320	2,826,861	31,208	6,287,995	17,001	2,968,708	2,063,619	7,409,623	
Puerto Rico	61,990	57,398	321,221	@	@	*	*	*	*	
Rhode Island	—	19,018	1,004,113	227	2,229,529	7,139	—	335,010	1,131,572	
South Carolina	—	58,791	—	12,057	—	12,927	—	1,441,828	2,689,777	
South Dakota	10,892	7,977	43,594	888	167,934	4,630	1,343,724	165,392	88,583	
Tennessee	137,370	100,677	616,503	5,011	508,457	22,282	5,504,008	951,194	6,210,656	
Texas	250,427	171,035	844,113	11,226	1,676,131	83,455	22,072,060	4,024,345	6,537,085	
Utah	9,770	9,285	63,571	1,739	292,829	3,791	987,699	195,211	580,887	
Vermont	12,354	8,832	68,897	316	26,620	3,011	685,061	284,805	505,454	
Virgin Islands	957	886	5,545	—	—	*	*	1,033	25,462	
Virginia	85,382	61,923	616,500	2,814	226,521	16,733	4,164,058	1,231,584	3,414,350	
Washington	68,655	65,238	257,153	21,437	5,350,229	1,843	349,428	1,486,350	2,451,987	
West Virginia	39,110	14,158	223,075	277	13,826	—	—	3,263,237	1,453,196	
Wisconsin	69,598	50,980	375,758	42,740	7,772,404	24,867	4,438,707	613,909	6,034,381	
Wyoming	—	2,139	—	515	—	608	—	—	—	

¹ As with other tables reporting medicare recipients and expenditures, the figures in this table include medicare recipients who are jointly eligible for medicare coverage.

"—" Data not available.

* Services not provided.

@ Skilled nursing facility services provided in public facilities; no Federal financial participation claimed.

SOURCE: Office of Research and Demonstrations, HCFA, these data were taken from Annual reports filed by the States. Because of nonreporting, the data in this table may not correspond to the data in Table 4.10 or in Chapter II.

TABLE 4.13

Early Periodic Screening, Diagnosis, and Treatment Services
 Provided to Medicaid Children, by Jurisdiction, Fiscal Year 1980

Medicaid Jurisdiction	Number of Screenings			
	Total Number of Recipients Screened (thousands)	Individuals Under Age 6 (thousands)	Individuals 6-20 (thousands)	Individuals Age 21 During Part of Reporting (thousands)
All Reporting Jurisdictions	1,671.9 ¹	784.6	822.5	7.4
Alabama	37.5	16.5	21.0	—
Alaska ²	—	—	—	—
Arkansas	28.0	15.9	12.1	(Z)
California ³	79.0 ¹	46.0	21.6	1.8
Colorado	25.7	14.6	11.0	(Z)
Connecticut	—	—	—	—
Delaware	3.4	2.1	1.3	—
District of Columbia	19.7	9.3	9.4	1.0
Florida	69.5	31.5	38.0	—
Georgia	74.1	39.0	35.0	0.1
Guam ²	—	—	—	—
Hawaii ³	2.8	1.6	1.2	(Z)
Idaho	10.5	5.7	4.8	—
Illinois	130.5	88.8	41.7	—
Indiana	127.4	49.4	78.0	—
Iowa	17.3	7.8	9.4	0.1
Kansas	14.8 ¹	5.4	8.3	—
Kentucky ³	24.1	8.3	15.8	—
Louisiana	56.2	28.7	27.5	—
Maine	56.9	14.2	42.7	—
Maryland	—	—	—	—
Massachusetts	28.2	16.9	11.3	—
Michigan ³	48.8	21.9	26.9	—
Minnesota	16.4	9.1	7.3	—
Mississippi	82.2	27.4	54.8	—
Missouri	27.5 ¹	11.6	13.3	—
Montana	2.7	1.5	1.2	—
Nebraska	9.1	4.0	5.1	(Z)
Nevada	5.4 ¹	1.6	2.8	—
New Hampshire	2.0	0.8	1.2	(Z)
New Jersey	48.3	21.4	26.8	0.1
New Mexico	11.6 ¹	4.2	6.3	0.1
New York ²	—	—	—	—
North Carolina	51.3	29.8	21.5	—
North Dakota ³	1.7	0.7	1.0	—

(continued)

TABLE 4.13 (continued)
Early Periodic Screening, Diagnosis, and Treatment Services
Provided to Medicaid Children, by Jurisdiction, Fiscal Year 1980

Medicaid Jurisdiction	Number of Screenings			
	Total Number of Recipients Screened (thousands)	Individuals Under Age 6 (thousands)	Individuals 6-20 (thousands)	Individuals Age 21 During Part of Reporting (thousands)
Ohio	45.3	22.1	23.0	0.2
Oklahoma	17.2	6.8	10.3	0.1
Oregon	39.5 ¹	—	—	—
Pennsylvania	153.0 ¹	67.0	83.9	1.5
Puerto Rico	—	—	—	—
Rhode Island	11.8	7.7	4.2	—
South Carolina	—	—	—	—
South Dakota	(Z)	(Z)	—	—
Tennessee	65.1	28.3	36.7	0.1
Texas	69.6	33.0	36.6	—
Utah	7.4	3.4	3.9	0.1
Vermont	9.4 ¹	5.1	3.8	0.3
Virgin Islands	1.0	0.7	0.3	(Z)
Virginia	41.7	25.1	16.6	—
Washington	41.7	23.9	16.4	1.4
West Virginia	28.2	15.1	13.1	—
Wisconsin	28.4 ¹	10.7	15.4	0.5
Wyoming ²	—	—	—	—

¹ Includes individuals reported with unknown age distribution. California reported 9,600 unknowns; Kansas, 1,100; Missouri, 2,600; Nevada, 1,000; New Mexico, 1,000; Oregon, 39,500; Pennsylvania, 600; Vermont, 200; and Wisconsin, 1,800.

² No 2082 report.

³ Based on 6 months of data for FY 1980.

"—" Data not available.

(Z) Indicates less than 0.05 percent of the total.

SOURCE: Office of Research and Demonstrations, HCFA, these data were taken from Annual reports filed by the States.

TABLE 4.14

Estimated Number of Medicaid Sterilizations, by State,
Calendar Year 1980¹

Jurisdictions	Sterilizations
All Reporting Jurisdictions	86,597
Alabama	1,504
Alaska	88
Arizona	—
Arkansas	1,271
California	12,901
Colorado	554
Connecticut	484
Delaware	187
District of Columbia	569
Florida	2,085
Georgia	1,279
Guam	—
Hawaii	877
Idaho	291
Illinois	5,582
Indiana	1,542
Iowa	1,075
Kansas	783
Kentucky	2,331
Louisiana	2,301
Maine	1,125
Maryland	1,709
Massachusetts	1,923
Michigan	4,450
Minnesota	606
Mississippi	1,257
Missouri	766
Montana	151
Nebraska	141
Nevada	96
New Hampshire	222
New Jersey	5,607
New Mexico	563
New York	9,432
North Carolina	1,384
North Dakota	57
Ohio	2,681
Oklahoma	856
Oregon	1,382
Pennsylvania	2,265
Puerto Rico	—
Rhode Island	497
South Carolina	696
South Dakota	111
Tennessee	1,700
Texas	3,426
Utah	247
Vermont	302
Virgin Islands	—
Virginia	1,488
Washington	3,094
West Virginia	688
Wisconsin	1,901
Wyoming	66

¹ Previous year table included breakdown by sex and type of procedure. This information is no longer reported by the States.

"—" Data not available.

SOURCE: Gerzowski Michele, Scott Berlucchi, and Allen Dobson, "Sterilizations, 1975-1980," in preparation, Office of Research and Demonstrations, HCFA.

TABLE 4.15

Vendor Payments for Medicaid Recipients, by Basis of
Eligibility and Maintenance Assistance Status,
Fiscal Year 1980

Basis of Eligibility	Total Payments (millions)	Distribution of Payments by Maintenance Assistance Status	
		Percent Cash Assistance	Percent Medical Assistance Only
Total	\$23,301.1	52.6	47.4
Age 65 and over	8,686.7	25.5	74.5
Blind	142.9	63.2	36.8
Permanently and Totally Disabled	7,014.9	60.9	39.1
Dependent Children under 21	3,170.2	84.6	15.4
Adults in Families with Dependent Children	3,372.4	87.6	12.4
Other Title XIX Recipients	913.9	Not applicable	100.0

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

Table 4.16 reports Medicaid expenditures for FY 1980 by State and basis of eligibility. The "age 65 and over" group accounts for the largest share of total vendor payments (37.3 percent), even though this group represents only 15.8 percent of all recipients in FY 1980 (see Table 4.5). The "permanently and totally disabled" also account for a disproportionate share of total vendor payments (30.1 percent of total vendor payments for 12.6 percent of total recipients). In contrast, AFDC recipients, though representing 65.1 percent of all recipients, accounted for only 28.1 percent of total vendor payments. Table 4.16 also ranks each State by its share of total vendor payments. New York and California alone accounted for 31.2 percent of all vendor payments in FY 1980, and seven States accounted for over 50 percent of the total. (These seven States also rank high in number of recipients.)

Table 4.17 ranks each Medicaid program by number of recipients (see Table 4.5) and total vendor payments (see Table 4.16). With some exceptions, the two rankings are closely related. The most noticeable exception is Puerto Rico which ranks 3rd in number of recipients, but only 38th in terms of total vendor payments. (This inconsistency reflects the Congressionally mandated expen-

TABLE 4.16

Medicaid Payments by Jurisdiction, Rank of Jurisdiction, and Basis of Eligibility, Fiscal Year 1980

Medicaid Jurisdiction	Total Payments (millions)	Percent of Total	Cumulative Percent of National Total ¹	Percent Distribution by Basis of Eligibility ¹				
				Age 65 and Over	Blind	Disabled	AFDC	Other Title XIX Recipients
All Jurisdictions	\$23,301.1	100.0	100.0	37.3	.6	30.1	28.1	4.0
New York	4,542.0	19.5	19.5	45.6	.7	27.5	17.7	8.5
California	2,728.2	11.7	31.2	27.4	1.0	31.1	35.6	4.9
Illinois	1,191.9	5.1	36.3	20.2	.2	39.0	40.0	.5
Michigan	1,071.7	5.0	40.9	25.9	.3	33.1	39.7	.9
Pennsylvania	1,058.2	4.5	45.5	34.6	.5	33.8	29.3	17.2
Massachusetts	1,009.3	4.3	49.7	48.6	1.1	30.2	19.2	2.3
Texas	980.9	4.2	53.9	50.4	.6	32.0	17.0	—
Ohio	809.4	3.5	57.4	33.6	.5	32.3	33.5	—
New Jersey	755.9	3.2	60.7	36.7	.2	25.7	31.3	6.1
Wisconsin	685.9	2.9	63.6	41.2	.6	32.7	23.4	2.1
Minnesota	590.4	2.5	66.1	45.9	.4	34.9	14.4	4.3
Georgia	462.4	2.0	68.1	36.7	.8	40.5	21.7	.2
Louisiana	415.2	1.8	69.9	42.2	.6	35.6	21.2	.5
North Carolina	401.1	1.7	71.6	39.2	1.3	33.2	23.7	2.6
Florida	392.0	1.7	73.3	43.7	.6	30.1	25.6	—
Tennessee	379.5	1.6	74.9	39.0	.8	37.2	21.7	1.4
Virginia	359.0	1.5	76.5	42.1	.6	31.0	25.3	1.1
Indiana	354.2	1.5	78.0	42.6	.7	37.6	19.1	—
Connecticut	349.7	1.5	79.5	45.2	.2	28.4	26.1	(Z)
Washington	329.0	1.4	80.9	39.8	.4	26.6	27.8	5.4
Maryland	319.6	1.4	82.3	35.9	.2	21.7	42.3	—
Kentucky	295.6	1.3	83.6	32.3	.7	34.1	31.6	1.3
Missouri	295.1	1.3	84.8	41.6	1.3	28.1	29.0	(Z)
Oklahoma	265.4	1.1	86.0	43.1	.2	30.5	26.1	(Z)
Alabama	263.5	1.1	87.1	47.4	.6	28.7	23.4	—
South Carolina	259.2	1.1	88.2	46.9	.8	29.4	22.0	.9
Arkansas	234.7	1.0	89.2	42.4	1.1	34.6	17.7	4.2
Iowa	230.2	1.0	90.2	41.1	.6	30.0	26.0	2.3
Mississippi	211.0	.9	91.1	48.7	.7	23.8	26.6	.1
Kansas	201.8	.9	92.0	34.4	.4	32.6	23.7	8.9
Colorado	181.7	.8	92.8	41.5	1.0	33.4	20.7	3.5
Oregon	178.9	.8	93.5	30.9	2.3	30.3	26.2	10.3

(continued)

TABLE 4.16 (continued)

Medicaid Payments by Jurisdiction, Rank of Jurisdiction, and Basis of Eligibility, Fiscal Year 1980

Medicaid Jurisdiction	Total Payments (millions)	Percent of Total	Cumulative Percent of National Total ¹	Percent Distribution by Basis of Eligibility ¹				Other Title XIX Recipients
				Age 65 and Over	Blind	Disabled	AFDC	
District of Columbia	168.5	.7	94.6	49.3	.4	34.9	15.1	.3
Rhode Island	160.4	.7	93.9	21.4	.1	33.0	45.4	(Z)
Maine	131.3	.6	95.2	13.3	.3	27.8	57.1	1.5
Nebraska	108.8	.5	95.7	44.2	.7	32.9	20.1	2.1
West Virginia	103.6	.4	96.1	29.0	.5	21.4	38.0	11.2
Puerto Rico	99.5	.4	96.5	—	.1	4.4	42.6	52.9
Hawaii	96.2	.4	96.9	35.7	.2	22.8	38.5	2.8
Utah	79.6	.3	97.3	32.3	.2	37.5	20.5	9.5
New Hampshire	71.9	.3	97.6	61.1	1.7	20.2	16.7	.2
New Mexico	70.3	.3	97.9	26.2	1.3	38.6	32.7	1.3
Montana	62.3	.3	98.2	43.3	.8	35.1	19.4	1.3
Vermont	59.3	.3	98.4	39.1	.2	34.6	24.7	1.3
South Dakota	54.9	.2	98.6	47.7	.3	35.6	15.8	.6
Idaho	52.0	.2	98.9	38.0	.2	36.8	24.4	.7
North Dakota	46.7	.2	99.1	59.4	.2	16.4	21.0	3.0
Delaware	45.3	.2	99.3	32.2	.3	31.4	34.4 ²	1.6
Nevada	44.9	.2	99.5	40.4	1.6	38.2	18.2	1.6
Alaska	26.7	.1	99.6	27.5	.7	47.6	23.0	1.3
Wyoming	14.4	(Z)	99.7	51.6	1.5	21.4	26.9	—
Virgin Islands	1.6	(Z)	100.0	19.3	.4	6.0	66.9	7.3

¹ May not sum to 100 percent because of rounding.² Includes unknown proportion of Other Title XIX recipients that State was unable to identify separately.

"—" Data not available.

(Z) Percent less than 0.05.

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

TABLE 4.17

Medicaid Jurisdictions Ranked by Number of Medicaid Recipients and Payments, Fiscal Year 1980

Medicaid Jurisdiction	Ranking by	
	Number of Medicaid Recipients ¹	Payments for Medicaid Recipients ²
California	1	2
New York	2	1
Puerto Rico	3	38
Pennsylvania	4	5
Illinois	5	3
Michigan	6	4
Ohio	7	8
Massachusetts	8	6
Texas	9	7
New Jersey	10	9
Florida	11	15
Georgia	12	12
Wisconsin	13	10
Kentucky	14	22
North Carolina	15	14
Louisiana	16	13
Tennessee	17	16
South Carolina	18	26
Minnesota	19	11
Alabama	20	25
Missouri	21	23
Virginia	22	17
Washington	23	20
Maryland	24	21
Mississippi	25	29
Oregon	26	32
Oklahoma	27	24
Arkansas	28	27
Connecticut	29	19
Indiana	30	18
Iowa	31	28
Kansas	32	30
Maine	33	35
Colorado	34	31
West Virginia	35	37
Rhode Island	36	34
District of Columbia	37	33
Hawaii	38	39
New Mexico	39	42
Nebraska	40	36
Utah	41	40
Vermont	42	44
Delaware	43	48
Montana	44	43
New Hampshire	45	41
Idaho	46	46
South Dakota	47	45
North Dakota	48	47
Nevada	49	49
Alaska	50	50
Virgin Islands	51	52
Wyoming	52	51

¹ From Table 4.5² From Table 4.16.SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

diture "cap" placed on Puerto Rico in 1972.) Kentucky (14th in recipients and 22nd in expenditures), Minnesota (19th in recipients and 11th in expenditures), South Carolina (18th in recipients and 26th in expenditures), Indiana (30th in recipients and 18th in expenditures), and Connecticut (29th in recipients and 19th in expenditures) are the only other Medicaid programs that showed a noticeable divergence in relative rankings in FY 1980.

Table 4.18 shows the distribution of vendor payments in each program by age and sex of those receiving services. Medicaid programs vary widely in vendor payments across different age groups. Greater consistency exists with respect to sex, with females accounting for the larger share of total vendor payments in all jurisdictions.

Table 4.19 shows the distribution of vendor payments across service categories in each program. Among reporting programs, 30.7 percent of all vendor payments went for inpatient hospital services (including general and mental hospitals), followed closely by ICF's (26.6 percent) and SNF's (15.9 percent). The percent of total payments for general hospital services ranged from a low of 13.4 in Minnesota to a high of 56.6 in the District of Columbia. For SNF's, the low was under .05 percent in Maryland and Oklahoma, and the high was 41.6 in Connecticut. For ICF's, (including ICF/MR), the respective figures were 2.1 percent in California and 63.2 in South Dakota.

Table 4.20 shows total Medicaid expenditures by form of payment. Provider payments under Medicaid may be made directly to the vendor or through a fiscal agent. State Medicaid agencies also may make premium or *per capita* payments to the Social Security Administration (in the case of Medicare-eligible, aged, or disabled "buy-in" recipients) or to health insuring agencies or HMO's. In general, almost all Medicaid payments (98 percent) are made directly to the vendor or through a fiscal agent (rather than as a premium or *per capita* payment).

Table 4.21 ranks each State by the ratio of Medicaid recipients to persons living at or below the U.S. poverty level, as defined by the Census Department. (It should be noted that these ratios in Table 4.21 include persons receiving State-only services.) Average expenditures per Medicaid recipient and average *per capita* personal income are also reported for each State. For the U.S. as a whole, the ratio of Medicaid recipients to persons below the poverty level was 54 to 100. The average annual expenditures per Medicaid recipient was \$1,078. The ratio of Medicaid recipients living at or below the poverty level ranged from a low of 23 in South Dakota to a high of 97 in California. Average expenditures per Medicaid recipient ranged from a low of \$72 in Puerto Rico to a high of \$1,985 in New York.

Table 4.22 shows "State-only" expenditures in FY 1980 for those reporting States that cover persons and/or services not eligible for Federal matching assistance. Of those States reporting "State-only" expenditures in FY 1980, California and New York together accounted for 76.0 percent of the total.

TABLE 4.18
Medicaid Payments by Jurisdiction, Age and Sex, Fiscal Year 1980

Medicaid Jurisdiction	Total Payments (millions)	Average Payment Per Recipient	Percent Distribution of Payments by Age and Sex ¹				
			Age			Sex	
			0-20	21-64	65 +	Male	Female
All Jurisdictions	\$23,301.1	\$1,078	21.0	42.3	36.8	33.5	66.5
Alabama	263.5	812	17.0	31.8	51.2	28.2	72.0
Alaska	26.7	1,554	—	—	—	—	—
Arkansas	234.7	1,054	20.0	33.0	47.1	33.3	66.7
California	2,728.2	798	24.4	40.3	12.4	32.6	67.4
Colorado	181.7	1,286	18.9	36.6	44.5	34.3	65.7
Connecticut	349.7	1,615	16.1	37.5	46.0	34.1	65.9
Delaware	45.3	920	26.2	41.0	32.9	32.6	66.9
District of Columbia	168.5	1,330	23.0	57.9	19.2	35.1	64.8
Florida	392.0	783	18.2	33.1	48.5	28.4	71.3
Georgia	462.4	1,075	16.6	36.1	47.4	27.4	53.5
Guam	—	—	—	—	—	—	—
Hawaii	96.2	902	23.0	41.1	36.0	38.0	62.0
Idaho	52.0	1,182	22.3	38.5	39.1	34.9	65.1
Illinois	1,191.9	1,137	24.5	50.2	25.3	34.4	65.6
Indiana	354.2	1,726	10.0	42.0	48.0	30.4	69.6
Iowa	230.2	1,290	21.4	36.2	42.4	33.9	66.1
Kansas	201.8	1,355	22.7	41.0	34.6	36.2	63.6
Kentucky	295.6	721	—	—	—	—	—
Louisiana	415.2	1,137	—	—	—	—	—
Maine	131.3	902	22.1	39.3	38.6	35.6	64.4
Maryland	319.6	1,023	24.8	37.2	38.0	30.4	69.5
Massachusetts	1,009.3	1,302	10.5	41.0	48.4	32.2	67.8
Michigan	1,071.7	1,101	21.7	50.5	27.8	32.6	67.4
Minnesota	590.4	1,814	14.3	36.7	49.0	37.8	62.2
Mississippi	211.0	688	18.0	32.8	49.1	29.2	70.8
Missouri	295.1	918	14.0	38.0	45.5	30.1	69.9
Montana	62.3	1,361	16.9	36.8	46.1	36.0	63.6
Nebraska	108.8	1,526	18.1	36.4	45.5	34.8	64.6
Nevada	44.9	1,781	21.9	32.9	41.2	36.0	63.9
New Hampshire	71.9	1,603	10.1	27.8	62.0	28.9	71.0
New Jersey	755.9	1,118	24.3	36.7	39.0	34.4	65.6
New Mexico	70.3	800	19.5	46.0	29.7	33.3	65.3
New York	4,542.0	1,985	—	—	—	—	—
North Carolina	401.1	1,065	18.1	42.2	39.7	34.0	66.2
North Dakota	46.7	1,489	14.8	23.6	59.2	34.3	65.7
Ohio	809.4	1,001	21.8	41.6	36.6	31.5	68.5
Oklahoma	265.4	1,046	24.6	31.2	44.2	35.8	64.2
Oregon	178.9	646	—	—	—	—	—
Pennsylvania	1,058.2	846	23.5	50.3	26.0	38.7	61.3
Puerto Rico	99.5	72	39.5	60.5	0.0	—	—
Rhode Island	160.4	1,255	9.8	37.1	53.1	34.0	66.1
South Carolina	259.2	768	—	—	—	—	—
South Dakota	54.9	1,575	13.2	34.6	52.2	36.7	63.2
Tennessee	379.5	1,071	19.2	38.2	42.5	32.4	67.1
Texas	980.9	1,426	15.2	34.1	50.7	31.7	68.3
Utah	79.6	1,387	25.4	41.3	33.3	37.3	62.7
Vermont	59.3	1,102	21.2	38.2	40.5	34.8	65.2
Virgin Islands	1.6	119	45.4	35.2	19.3	31.9	68.1
Virginia	359.0	1,120	18.8	38.4	42.7	33.2	66.8
Washington	329.0	1,044	19.2	41.2	39.6	29.6	64.7
West Virginia	103.6	801	22.6	32.6	14.2	7.5	19.6
Wisconsin	685.9	1,616	17.9	36.1	43.8	35.7	64.3
Wyoming	14.4	1,037	—	—	—	—	—

¹ Percentages may not sum to 100 percent because of unknowns and rounding.

“—” Data not available.

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

TABLE 4.19

Medicaid Vendor Payments and Percent Distribution, by Type of Medical Service
and Jurisdiction, Fiscal Year 1980

Medicaid Jurisdiction	Total Payments (millions)	Percent Distribution by Type of Medical Service					
		Inpatient Hospital Services		Skilled Nursing Facility Services	Intermediate Care Facility Services in Institutions		Physicians' Services
		General Hospital	Mental Hospital		For Mentally Retarded	All Other Institutions	
All Reporting Jurisdictions	\$23,301.1	27.0	3.7	15.9	8.5	18.1	8.0
Alabama	263.5	22.7	(Z)	14.5	2.9	32.5	11.0
Alaska	26.7	18.2	(Z)	8.8	21.9	34.9	7.0
Arkansas	234.7	19.7	0.1	12.3	10.9	28.8	10.2
California	2,728.2	35.1	0.9	21.2	1.2	0.9	16.8
Colorado	181.7	18.3	2.8	13.0	14.2	28.9	5.2
Connecticut	349.7	18.4	13.6	41.6	0.1	4.8	4.7
Delaware	45.3	26.8	2.0	0.7	14.4	28.7	11.1
District of Columbia	168.5	54.8	—	1.3	5.6	8.1	8.6
Florida	392.0	32.7	1.5	14.4	3.5	20.4	8.8
Georgia	462.4	25.3	—	13.5	8.4	21.8	10.0
Guam	—	—	—	—	*	*	—
Hawaii	96.2	21.4	—	20.7	9.4	12.8	15.2
Idaho	52.0	17.5	—	18.5	14.0	25.7	8.1
Illinois	1,191.9	35.7	7.3	8.5	—	18.9	9.2
Indiana	354.2	21.4	0.6	12.7	7.3	39.4	5.1
Iowa	230.2	18.2	0.9	0.5	17.1	40.1	8.2
Kansas	201.8	23.4	3.1	1.1	16.4	32.8	6.1
Kentucky	295.6	25.9	0.9	6.3	7.0	27.0	12.8
Louisiana	415.2	20.0	0.5	0.9	15.8	34.9	8.9
Maine	131.3	23.5	—	2.5	—	46.5	9.1
Maryland	319.6	41.4	—	(Z)	—	33.4	6.5
Massachusetts	1,009.3	38.2	1.9	18.1	N/A	16.5	5.1
Michigan	1,071.7	33.0	2.2	12.5	9.5	15.0	13.0
Minnesota	590.4	13.4	1.9	29.0	19.7	17.8	5.9
Mississippi	211.0	25.6	—	23.3	4.6	13.8	11.8
Missouri	295.1	26.8	(Z)	1.3	10.3	34.0	6.1
Montana	62.3	20.0	(Z)	3.3	7.3	44.6	9.8
Nebraska	108.8	19.5	2.2	5.5	14.0	37.6	6.1
Nevada	44.9	29.1	0.9	2.1	8.2	38.5	9.6
New Hampshire	71.9	15.0	(Z)	5.1	5.7	56.1	5.1
New Jersey	755.9	21.5	5.9	1.9	7.3	35.7	7.2
New Mexico	70.3	28.9	—	1.4	9.2	23.2	15.6
New York	4,542.6	24.8	8.7	24.0	6.4	12.3	3.0
North Carolina	401.1	26.3	2.6	14.2	11.1	17.4	8.1
North Dakota	46.7	19.1	4.4	33.6	—	21.0	7.9
Ohio	809.4	28.8	3.3	22.8	8.6	12.1	7.3
Oklahoma	265.4	25.4	1.6	(Z)	10.4	40.5	8.2
Oregon	178.9	16.6	3.2	2.6	20.6	29.0	10.5
Pennsylvania	1,058.2	28.4	9.3	16.9	19.4	7.2	3.6
Puerto Rico	99.5	29.6	—	@	*	*	—
Rhode Island	160.4	35.1	1.1	1.3	14.5	32.1	3.3
South Carolina	259.2	23.9	5.0	10.2	12.3	24.2	9.4
South Dakota	54.9	15.4	—	6.4	20.4	42.8	6.4
Tennessee	379.5	21.8	1.7	3.8	11.6	31.2	9.2
Texas	980.9	17.6	—	4.1	16.3	39.8	10.2
Utah	79.6	20.5	2.1	10.0	20.1	28.6	7.6
Vermont	59.3	17.9	5.6	1.6	16.0	31.0	11.4
Virgin Islands	1.6	45.0	—	—	*	*	2.5
Virginia	359.0	23.0	0.2	2.6	15.1	31.7	9.5
Washington	329.0	25.0	0.4	38.0	0.7	2.7	10.0
West Virginia	103.6	34.0	—	0.2	1.0	29.6	14.8
Wisconsin	685.9	15.5	1.6	35.9	8.2	16.8	4.1
Wyoming	14.4	25.1	—	11.5	—	47.5	10.2

(continued)

TABLE 4.19 (continued)

**Medicaid Vendor Payments and Percent Distribution, by Type of Medical Service
and Jurisdiction, Fiscal Year 1980**

Medicaid Jurisdiction	Percent Distribution by Type of Medical Service								
	Dental Services	Other Practitioners' Services	Outpatient Hospital Services	Clinic Services	Laboratory & Radiological Services	Home Health Services	Prescribed Drugs	Family Planning Services	Other
All Reporting Jurisdictions	2.0	0.8	4.7	1.4	0.5	1.4	5.7	0.3	1.9
Alabama	1.4	(Z)	4.4	*	1.4	0.6	7.6	0.3	0.8
Alaska	1.9	0.9	2.9	0.4	(Z)	0.1	*	0.1	2.8
Arkansas	2.1	0.5	2.8	0.4	0.1	0.1	9.1	0.6	2.3
California	3.4	2.4	6.0	0.7	1.0	0.1	6.3	0.3	3.5
Colorado	1.2	1.0	4.4	3.2	0.3	0.4	6.0	0.3	1.0
Connecticut	1.1	0.9	4.9	2.4	0.4	1.2	4.5	(Z)	1.5
Delaware	0.7	0.4	6.8	0.2	0.7	0.7	4.5	2.0	0.3
District of Columbia	0.7	0.8	9.8	0.9	0.5	1.7	3.5	0.3	3.4
Florida	1.2	0.2	5.8	*	0.1	0.2	9.7	0.2	1.4
Georgia	2.1	0.4	4.0	1.7	0.1	0.6	9.9	0.4	1.7
Guam	—	—	—	—	—	—	—	—	—
Hawaii	6.8	1.0	3.7	0.2	1.4	0.3	4.9	0.9	1.2
Idaho	1.8	0.2	3.5	(Z)	2.0	0.4	4.3	0.6	3.4
Illinois	2.7	1.0	3.8	3.5	0.6	0.2	7.7	—	0.9
Indiana	0.8	0.5	2.0	0.2	0.2	0.4	7.5	0.3	1.7
Iowa	3.0	1.1	2.6	0.3	0.1	0.2	6.1	0.6	0.9
Kansas	2.0	1.0	2.7	2.8	0.9	0.3	6.5	0.4	0.6
Kentucky	3.3	0.5	4.7	3.4	0.1	1.4	5.0	0.8	1.0
Louisiana	1.6	(Z)	3.0	1.4	0.2	0.1	11.0	0.3	1.4
Maine	1.6	1.0	4.8	0.8	(Z)	0.8	6.3	0.1	1.8
Maryland	2.1	0.8	9.8	—	0.3	0.3	5.1	—	0.3
Massachusetts	2.5	—	7.7	2.5	—	2.0	5.0	—	3.5
Michigan	2.1	0.8	2.2	0.1	1.3	0.2	6.5	0.7	0.9
Minnesota	2.1	0.7	2.2	0.1	(Z)	0.5	4.0	0.4	2.7
Mississippi	2.1	0.4	3.5	(Z)	0.2	0.4	12.7	0.8	0.8
Missouri	3.7	1.1	4.9	1.7	0.2	0.3	8.6	0.4	0.6
Montana	3.0	1.6	2.3	0.5	0.2	0.5	4.6	0.2	2.0
Nebraska	1.6	0.9	2.1	1.4	0.3	0.6	7.2	0.5	0.7
Nevada	1.6	0.8	2.1	(Z)	0.2	0.7	3.7	0.5	1.9
New Hampshire	1.0	0.8	3.0	1.4	0.2	0.9	4.7	0.2	1.0
New Jersey	2.9	0.8	5.5	0.7	0.5	1.2	5.7	0.5	1.5
New Mexico	3.2	1.1	5.8	0.9	0.4	0.7	7.5	0.2	2.0
New York	1.1	0.3	5.7	2.6	0.4	5.6	2.6	0.3	2.3
North Carolina	3.5	0.4	3.7	2.2	0.5	0.3	8.1	0.4	0.5
North Dakota	3.4	1.4	1.6	0.8	0.2	0.1	5.8	0.1	0.7

(continued)

TABLE 4.19 (continued)

**Medicaid Vendor Payments and Percent Distribution, by Type of Medical Service
and Jurisdiction, Fiscal Year 1980**

Medicaid Jurisdiction	Percent Distribution by Type of Medical Service								
	Dental Services	Other Practitioners' Services	Outpatient Hospital Services	Clinic Services	Laboratory & Radiological Services	Home Health Services	Prescribed Drugs	Family Planning Services	Other
Ohio	1.8	1.2	6.2	0.5	0.2	0.1	5.9	0.1	1.2
Oklahoma	1.1	0.1	0.4	*	0.8	(Z)	3.2	0.1	8.2
Oregon	3.1	1.2	3.7	—	1.5	0.1	4.9	0.8	2.3
Pennsylvania	1.1	0.4	2.4	1.5	0.5	0.2	5.6	0.2	0.9
Puerto Rico	1.0	*	70.4	*	*	*	*	*	*
Rhode Island	1.8	0.3	4.0	—	0.2	0.2	5.0	0.2	1.0
South Carolina	2.1	0.4	3.2	—	1.0	0.5	6.9	0.6	1.2
South Dakota	1.0	0.4	1.8	0.5	0.3	(Z)	3.5	0.3	0.8
Tennessee	1.3	0.2	4.0	2.4	0.7	0.4	11.0	0.2	0.7
Texas	0.5	0.7	2.1	(Z)	0.8	0.1	6.5	0.4	0.9
Utah	0.5	0.8	2.2	0.4	0.7	0.1	4.8	0.5	1.1
Vermont	1.7	0.7	3.7	0.1	1.0	1.8	5.9	0.8	1.0
Virgin Islands	0.8	*	32.2	—	0.2	—	11.9	0.7	6.7
Virginia	1.4	0.5	5.1	1.0	0.1	0.4	6.7	0.5	2.9
Washington	4.5	1.6	3.7	0.2	0.9	0.5	5.3	0.4	6.4
West Virginia	2.1	1.0	3.5	0.3	0.1	0.1	10.0	0.3	2.5
Wisconsin	2.7	1.9	2.9	3.1	0.1	0.5	5.3	0.2	1.4
Wyoming	1.3	0.6	2.9	—	0.1	0.1	(Z)	0.5	0.3

“—” Data not available.

(Z) Percentage less than 0.05.

* Services not covered.

@ Skilled nursing facility services provided in public facilities; no Federal financial participation claimed.

SOURCE: Office of Research and Demonstrations, HCFA, *Annual Medicaid Statistics*, unpublished.

TABLE 4.20

Total Payments under Medicaid, by Form of Payment, Fiscal Year 1980¹

Medicaid Jurisdictions ²	Total Payments ³ (Millions)	Directly to Vendor or Through Fiscal Agent (Millions)	Premium or Per Capita Payments			
			SSA System for		Health Insuring Agency (Millions)	Health Maintenance Organization (Millions)
			Aged Recipients (Millions)	Disabled Recipients (Millions)		
All Reporting Jurisdiction	\$24,197.7	\$23,301.1	\$269.3	\$68.7	\$419.7	\$139.1
Alabama	277.3	263.5	10.8	3.0		
Alaska	26.7	26.7				
Arkansas	241.7	234.7	5.5	1.5		
California	2,955.3	2,728.2	42.3	22.2	97.1	65.5
Colorado	184.7	181.7	1.7	.2		1.1
Connecticut	351.0	349.7	1.0	.3		
Delaware	45.7	45.3	.4	(Z)		
District of Columbia	169.9	168.5	.9	.3		.2
Florida	405.7	392.0	10.0	3.7		
Georgia	476.7	462.4	14.3			
Hawaii	98.6	96.2	.9	.3		1.2
Idaho	52.6	52.0	.5	.1		
Illinois	1,198.6	1,191.9	2.9	2.4		1.4
Indiana	358.4	354.2	2.9	1.3		
Iowa	263.3	230.2	26.1	7.0		
Kansas	202.8	201.8	.8	.2		
Kentucky	302.7	295.6	7.1			
Louisiana	415.2	415.2				
Maine	133.0	131.3	1.4	.3		
Maryland	337.5	319.6	2.8	2.1		12.9
Massachusetts ⁴	1,020.4	1,009.3	9.4			1.7
Michigan	1,119.3	1,071.7	4.6	3.3		39.7
Minnesota	592.4	590.4	1.2	.6		.2
Mississippi	218.9	211.0	7.3	.6		
Missouri	301.5	295.1	5.1	1.3		
Montana	63.2	62.3	.7	.2		
Nebraska	109.6	108.8	.5	.3		
Nevada	45.5	44.9	.5	.1		
New Hampshire	72.2	71.9	.3	(Z)		
New Jersey	763.8	755.9	6.1	1.8		
New Mexico	72.3	70.3	1.3	.7		
New York	4,571.2	4,542.0	21.6		1.5	6.1
North Carolina	408.1	401.1	5.8	1.2		
North Dakota	47.0	46.7	.3	(Z)		
Ohio	819.9	809.4	8.9	.3		1.3

(Continued)

TABLE 4.20 (continued)

Total Payments under Medicaid, by Form of Payment, Fiscal Year 1980¹

Medicaid Jurisdictions ²	Total Payments ³ (Millions)	Directly to Vendor or Through Fiscal Agent (Millions)	Premium or Per Capita Payments			
			SSA System for		Health Insuring Agency (Millions)	Health Maintenance Organization (Millions)
			Aged Recipients (Millions)	Disabled Recipients (Millions)		
Oklahoma	270.0	265.4	4.1	.5		
Oregon	181.4	178.9				2.5
Pennsylvania	1,068.6	1,058.2	5.9	3.7		.8
Puerto Rico	99.5	99.5				
Rhode Island	161.3	160.4	.5	.4		(Z)
South Carolina	267.1	259.2	6.1	1.8		
South Dakota	55.4	54.9	.5	(Z)		
Tennessee	389.6	379.5	10.1			
Texas	1,325.4	980.9	20.8	2.8	320.9	
Utah	82.3	79.6	.2	.1		2.4
Vermont	60.0	59.3	.7			
Virginia	366.1	359.0	3.7	3.4		
Virgin Islands	1.6	1.6				
Washington	334.0	329.0	2.2	.7		2.1
West Virginia	106.8	103.6	3.2			
Wisconsin	691.5	685.9	5.4		.2	(Z)
Wyoming	14.4	14.4				

¹ Totals do not add because of rounding.² No data available for Guam and Northern Marianas.³ These data are generated from monthly data whereas payment data in other tables come from annual reports. Year-end corrections in monthly estimates are responsible for the discrepancies between these two data sets.⁴ In Massachusetts, the 9.4 figure is for age recipients and disabled recipients. Individual breakdowns are not available.

(Z) Percentage less than 0.5.

SOURCE: Division of Medicaid Cost Estimates, Bureau of Data Management and Strategy, HCFA, unpublished data.

TABLE 4.21

Ratio of Medicaid Recipients to Persons Below the Poverty Level, Ranked by Jurisdiction, Fiscal Year 1980¹

Medicaid Jurisdiction	Percent of Medicaid Recipients Living at or Below the Poverty Level ²	Average Payment Per Medicaid Recipient ³	Per Capita Personal Income ⁴
Average All Jurisdictions	54	\$1,078	\$ 9,511
California	97	798	10,929
Hawaii	91	902	10,091
Massachusetts	88	1,302	10,118
Rhode Island	88	1,255	9,429
Oregon	82	646	9,296
New York	79	1,985	10,252
Alabama	75	812	7,434
District of Columbia	69	1,330	12,050
Maryland	69	1,023	10,477
Pennsylvania	68	846	9,427
Puerto Rico	67	72	3,494 ⁵
Maine	66	902	7,868
New Jersey	65	1,118	10,935
Michigan	63	1,101	9,967
Wisconsin	59	1,616	9,413
Washington	58	1,044	10,355
Alaska	57	1,554	12,759
Delaware	57	920	10,291
Illinois	57	1,137	10,479
Connecticut	52	1,615	11,692
Minnesota	50	1,814	9,765
South Carolina	50	768	7,265
Vermont	49	1,102	7,810
Kentucky	47	721	7,662
Ohio	44	1,001	9,460
Kansas	43	1,355	9,864
Oklahoma	41	1,046	9,066
Louisiana	40	1,137	8,456
Mississippi	40	688	6,557
New Hampshire	40	1,603	9,119
Iowa	39	1,290	9,310
Colorado	38	1,286	10,033
Arkansas	36	1,054	7,185
Tennessee	36	1,071	7,702
Montana	35	1,361	8,652
Virginia	35	1,120	9,406

(continued)

TABLE 4.21 (continued)

Ratio of Medicaid Recipients to Persons Below the Poverty Level, Ranked by Jurisdiction, Fiscal Year 1980¹

Medicaid Jurisdiction	Percent of Medicaid Recipients Living at or Below the Poverty Level ²	Average Payment Per Medicaid Recipient ³	Per Capita Personal Income ⁴
Georgia	34	1,075	8,041
Missouri	33	918	8,865
Idaho	32	1,182	8,176
Utah	32	1,387	7,681
West Virginia	32	801	7,814
Wyoming	32	1,307	10,875
New Mexico	31	800	7,878
North Carolina	30	1,065	7,832
Nevada	29	1,781	10,723
Florida	28	783	8,993
Indiana	27	1,726	8,924
North Dakota	26	1,489	8,626
Texas	25	1,426	9,528
Nebraska	24	1,526	9,086
South Dakota	23	1,575	7,818

¹ Guam and the Virgin Islands are not included in the table due to problems with data on the Medicaid program, population, and poverty.

² Numerator data were calculated from data submitted by the States to HCFA. The numerator includes an estimate of the total number of persons receiving Medicaid services in each state regardless of whether Federal monies were involved. Denominator data were developed from U.S. Bureau of Census data provided by the Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, DHHS. The denominator was adjusted to include an estimate of those receiving Medicaid who were not poor.

³ This average was calculated by dividing total expenditures, *exclusive of non-Medicaid recipient payments*, by the total number of Medicaid recipients as reported to HCFA.

⁴ Per capita personal income is for CY 1980 from Statistical Abstract of the United States, 1982-1983.

⁵ Preliminary figure from Economic Report to the Governor, Puerto Rico 1980.

SOURCES: Medicaid Data — Medicaid Program Data Branch, Office of Research and Demonstrations, HCFA; Income Data — *Survey of Current Business*, U.S. Department of Commerce, Vol. 60, No. 8, August 1980.

TABLE 4.22
Medicaid State-Only Expenditures,
Fiscal Year 1980

Jurisdiction ¹	Total Expenditures (millions)
All Reporting Jurisdictions	\$1,119.8
Alaska	1.9
California	549.1
Colorado	2.1
Georgia	.2
Hawaii	15.6
Illinois	124.2
Louisiana	1.1
Maine	2.3
Maryland	72.5
Massachusetts	4.3
Michigan	7.3
Montana	4.0
New York	299.8
North Carolina	1.4
North Dakota	.3
Oregon	15.9
South Dakota	.6
Utah	2.1
West Virginia	.6
Wisconsin	14.5

¹ Some Medicaid jurisdictions that are known to have State-only expenditures, such as Pennsylvania, have chosen not to report these expenditures for 1980. Alaska, Georgia, and New York were included in the Medicare and Medicaid Data Book, 1981, but did not report for FY 1980.

SOURCE: Office of Research and Demonstrations, HCFA. The data in this table were taken from the Monthly 120 reports filed by the States.

F. Financing

Under Medicaid, service providers (physicians, pharmacists, hospitals, etc.) may be reimbursed from several different sources, including:

- the Federal government, through Federal matching assistance payments;
- the Federal government, through Medicare Part B "buy-in" agreements;
- State governments;
- local governments (in some cases);
- third parties who are otherwise liable for care provided to Medicaid eligibles; and
- Medicaid recipients themselves.

This section presents data on each source of funds, except for private third parties and expenditures contributed by Medicaid recipients themselves.

1. Federal/State Financing

The Federal share of State medical vendor payments is determined by a statutory formula based on State *per capita* income, where

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times .45$$

and where Federal share = 1.00 minus the State share. By design, the formula sets higher rates of Federal matching for States with relatively low *per capita* incomes (up to a statutory maximum of 83 percent) and lower rates for States with relatively high *per capita* incomes (down to a minimum of 50 percent).

Table 4.23 shows the Federal Medicaid Assistance Percentages in effect for fiscal years 1980 through 1983. No State receives the maximum Federal match of 83 percent (Mississippi receives the highest at 77.36 percent), and 13 States receive the minimum. These percentages apply to medical vendor payments only. For fiscal year 1980, Federal matching rates for other expenditures were as follows:

- Family Planning Services were matched at 90 percent;
- administrative costs were matched at 50 percent;
- development of automated claims processing and management information systems was matched at 90 percent and the operation of such systems was matched at 75 percent;
- costs of skilled nursing facility inspectors were matched at 75 percent;
- costs of professional medical personnel used to administer the program were matched at 75 percent; and
- State Medicaid fraud and abuse units located organizationally outside of the single State agency were matched at 90 percent.

The share of total expenditures for medical assistance borne by the States will vary with the extent to which States provide medical assistance to State-only eligibles and offer services which do not qualify for Federal financial participation (FFP).

Table 4.23 also shows the total medical vendor payments subject to Federal financial participation, along with the Federal, State and local share of such payments. The expenditure data in Table 4.23 may differ from expenditure figures in other tables, because total payments computable for Federal funding represent only those payments for which FFP is allowed (while excluding other payments, such as Medicare SMI premiums paid on behalf of the medically needy for which FFP is not allowed). The *adjusted Federal share* is the official accounting of payments to providers and reflects such accounting adjustments as changes in payments to cost-reimbursed providers following year-end audits.

2. Local Funding Formulas

The non-Federal share of medical vendor payments may be provided out of State or local revenues. A State plan, however, must ensure that at least 40 percent of the non-Federal share is borne directly by the State. It must also guarantee that lack of local funds will not result in smaller amounts, duration, scope, or quality of care provided to Medicaid eligibles. As of February 1982, 13 States provided for local funding of the non-Federal share of Medicaid vendor payments. Table 4.23 presents the total expenditures financed by these local funding sources, for those States that reported these expenditures during FY 1980. Table 4.24 presents the local funding formulas used by all 13 States in February 1982.

TABLE 4.23
Medicaid Vendor Payments, by Jurisdiction, Fiscal Year 1980¹

Medicaid Jurisdiction	Total Payment Computable for Federal Funding ² (millions)	Percent Federal Share		Adjusted Federal Share (millions)	State Share (millions)	Local Share ³ (millions)
		FY 1980-1981	FY 1982-1983			
All Reporting Jurisdictions	\$23,930.3			\$13,316.1	\$10,614.4	\$1,130.1
Alabama	309.9	71.32	71.13	215.5	94.4	0
Alaska	37.2	50.00	50.00	19.1	18.1	0
Arkansas	242.7	72.87	72.16	177.8	64.9	0
California	2,887.7	50.00	50.00	1,458.7	1,429.0	0
Colorado	187.4	53.16	52.28	97.5	90.0	0
Connecticut	337.2	50.00	50.00	172.1	165.1	0
Delaware	44.4	50.00	50.00	23.1	21.3	0
District of Columbia	168.7	50.00	50.00	83.7	85.1	0
Florida	408.6	58.94	57.92	236.1	172.5	33.0
Georgia	477.6	66.76	66.28	318.6	159.0	0
Hawaii	94.4	50.00	50.00	48.2	46.2	0
Idaho	50.7	65.70	65.43	33.7	17.0	0
Illinois	1,242.1	50.00	50.00	678.1	564.0	0
Indiana	379.0	57.28	56.73	215.5	163.4	0
Iowa	236.2	56.57	55.35	133.5	102.7	47.0
Kansas	192.8	53.52	52.50	104.8	88.0	0
Kentucky	314.0	68.07	67.95	220.9	93.1	0
Louisiana	416.7	68.82	66.85	282.3	134.3	0
Maine	146.2	69.53	70.63	103.7	42.5	0
Maryland	422.7	50.00	50.00	213.3	209.4	0
Massachusetts	1,051.3	51.75	53.56	544.0	507.2	0
Michigan	1,154.5	50.00	50.00	570.7	583.7	0
Minnesota	592.7	55.64	54.39	325.5	267.2	23.2
Mississippi	224.7	77.55	77.36	176.5	48.2	0
Missouri	301.6	60.36	60.38	207.3	94.3	0
Montana	62.8	64.28	65.34	41.3	21.6	0
Nebraska	109.6	57.62	58.12	67.6	41.9	15.6
Nevada	45.4	50.00	50.00	23.7	21.7	0
New Hampshire	72.8	61.11	59.41	44.1	28.8	0
New Jersey	736.6	50.00	50.00	369.3	367.3	0
New Mexico	72.7	69.03	67.19	52.1	20.1	0
New York	4,362.1	50.00	50.88	2,176.3	2,185.9	966.0
North Carolina	422.3	67.64	67.81	277.5	144.8	28.5
North Dakota	48.8	61.44	62.11	29.4	19.3	2.7
Ohio	823.9	55.10	55.10	459.8	364.7	0
Oklahoma	273.1	63.64	59.91	172.5	100.6	0
Oregon	183.5	55.66	52.81	100.6	82.9	2.3
Pennsylvania	1,245.9	55.14	56.78	685.2	560.7	11.2
Rhode Island	154.5	57.81	57.77	93.3	61.2	0
South Carolina	264.7	70.97	70.77	181.9	82.8	0
South Dakota	57.4	68.78	68.19	39.2	18.3	0
Tennessee	380.5	69.43	68.53	265.9	114.6	0
Texas	979.8	58.35	55.75	571.9	407.9	0
Utah	74.1	68.07	68.64	56.5	17.6	.2
Vermont	60.8	68.40	68.59	43.0	17.8	0
Virginia	363.3	56.54	56.74	217.6	145.7	0
Washington	367.5	50.00	50.00	188.7	178.8	0
West Virginia	107.7	67.35	67.95	72.3	35.4	0
Wisconsin	725.6	57.95	58.02	419.1	306.5	0
Wyoming	14.5	50.00	50.00	7.1	7.4	0

¹ These data include prior period claims, collections, deferrals, disallowances, and suspensions taken by the regional office or paid in that fiscal year. As a result, these numbers differ from those in other tables which do not include the same adjustments.

² Includes only those payments for which FFP is allowed.

³ Data shown are only those reported to HCFA on a voluntary basis.

SOURCE: Health Care Financing Administration, Quarterly Report (HCFA-64), Bureau of Program Operations.

TABLE 4.24
Local Funding Formulas for Medicaid Vendor Payments, by State,
February 1982¹

State	Formula
Colorado	Twenty largest counties pay 2 percent of State's share for all new ICF nursing admissions.
Florida	County pays \$55/mo. for each nursing home resident; 35 percent of State share for I/P hospital days over 12 and less than 46; 100 percent of State share for certain outpatient services.
Iowa	Counties must match Federal funds for ICF-MR's.
Minnesota	Counties pay 10 percent of State's share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 14 percent of State's share.
New Hampshire	Counties pay approximately 25 percent of State's share.
New York	Counties pay 50 percent of non-Federal share.
North Carolina	Counties pay 15 percent of non-Federal share for all services except SNF's and ICF's for which they pay 35 percent of non-Federal share.
North Dakota	Counties pay 15 percent of State's share except for ICF-MR and two other services.
Pennsylvania	Counties pay 10 percent of State's share for county nursing homes plus \$3 per invoice administration fee.
South Dakota	\$60 per month for each ICF/MR resident and local school district for Crippled Children's Hospital.
Wisconsin	Local contribution of 10-20 percent for specific services, that is, mental health.

¹ Table includes only those States that reported local funding formulas.

SOURCE: Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982.

3. State Buy-In with Medicare

If an individual eligible for Medicaid under a State plan also qualifies for Medicare Part B coverage, a State can enroll that individual in Part B by paying his or her Part B premiums. Under this buy-in arrangement, some of the costs of providing care that would otherwise be borne by the State are instead borne by the Federal Government. (For a more detailed discussion, see Chapter I, Section C.1.)

Table 4.25 shows the number of individuals enrolled in Medicare Part B under a buy-in arrangement as of FY 1980. Also included are the numbers of such individuals receiving services and the total payments made under Medicare's SMI program on behalf of Medicaid beneficiaries. All but five jurisdictions buy into the Medicare SMI program.

G. Administrative Practices

1. Methods of Reimbursement

Medicaid regulations specify several criteria and methods for reimbursing providers. Table 4.26 shows the method of reimbursement by State for inpatient hospital services, long-term care services, outpatient hospital services, and physicians' services. The data are

taken from a survey of State Medicaid agencies conducted in the spring of 1982. Forty-eight States responded to the survey.²³

Before FY 1982, States were required by law to reimburse for inpatient hospital services on the same basis as Medicare—reasonable costs—unless they received approval from the Secretary of the Department of Health and Human Services (DHHS) to use an alternative method of reimbursement.²⁴ This requirement was dropped by

²³The survey instrument was designed by the LaJolla Corporation in association with the National Governor's Association and the Urban Institute.

²⁴An alternative method was to be approved only if it: (1) provided incentives for efficiency and economy; (2) provided for payment rates that are no higher than the amounts that would be determined using Medicare principles of cost reimbursement; (3) assured adequate participation of hospitals in the State's Medicaid program and the availability of hospital services of high quality to recipients; (4) afforded individual providers an opportunity to submit evidence and obtain prompt administrative review of payment rates set for them in certain instances; and (5) provided for documentation that is adequate for evaluation experience under the approved methods and standards. As of February 1982, 18 States had received approval from DHHS to use an alternative method for reimbursement of inpatient hospital services.

TABLE 4.25

Medicaid State Buy-ins with Medicare, by Jurisdiction,
Number of Persons Served, and Reimbursements,
Calendar Year 1980

Medicaid Jurisdiction	Number of State Buy-ins Enrolled (thousands)	Number of Persons with Reimbursed Services ¹ (thousands)	Total Reimburse- ment (millions)
All Reporting Jurisdictions	3,317.2	2,520.5	\$1,832.6
Alabama	126.4	85.5	40.8
Alaska ²	0.0	.1	.1
Arkansas	79.6	55.2	26.2
California	647.8	546.4	637.3
Colorado	35.9	28.6	16.2
Connecticut	11.9	9.5	7.0
Delaware	4.6	3.3	2.5
District of Columbia	15.9	11.8	15.4
Florida	147.2	114.6	107.2
Georgia	139.3	100.2	55.4
Guam	.6	.2	.1
Hawaii	12.1	10.0	8.4
Idaho	7.8	6.1	2.6
Illinois	53.8	43.1	36.5
Indiana	42.6	33.8	17.9
Iowa	39.1	28.7	13.8
Kansas	34.1	27.0	16.1
Kentucky	70.7	44.8	19.1
Louisiana ²	0.0	1.1	.9
Maine	17.9	13.3	6.7
Maryland	50.2	39.3	30.8
Massachusetts	101.1	75.6	54.4
Michigan	78.5	59.7	46.4
Minnesota	19.1	14.1	7.7
Mississippi	91.0	67.8	33.9
Missouri	63.3	46.6	24.8
Montana	9.7	7.2	4.2
Nebraska	8.3	6.1	3.4
Nevada	6.0	5.3	5.6
New Hampshire	3.3	2.4	1.2
New Jersey	83.8	66.6	57.3
New Mexico	19.4	13.0	8.4
New York	238.6	182.1	146.5
North Carolina	93.6	73.8	45.7
North Dakota	4.2	3.2	1.6

(continued)

TABLE 4.25 (continued)

Medicaid State buy-ins with Medicare, by Jurisdiction,
Number of Persons Served, and Reimbursements,
Calendar Year 1980

Medicaid Jurisdiction	Number of State Buy-ins Enrolled (thousands)	Number of Persons with Reimbursed Services ¹ (thousands)	Total Reimburse- ment (millions)
Ohio	100.8	83.5	51.9
Oklahoma	46.8	33.3	17.1
Oregon ²	0.0	1.1	.8
Pennsylvania	103.9	68.1	51.6
Puerto Rico ²	0.0	1.1	.9
Rhode Island	10.7	8.3	5.7
South Carolina	72.6	50.1	23.0
South Dakota	6.4	3.9	1.7
Tennessee	97.9	64.2	32.1
Texas	275.7	207.7	134.0
Utah	8.8	7.1	4.1
Vermont	6.8	4.8	2.0
Virgin Islands	1.0	.3	.1
Virginia	75.8	56.9	37.8
Washington	53.9	43.1	25.9
West Virginia	25.6	15.7	7.4
Wisconsin	53.5	37.4	20.4
Wyoming ²	0.0	.1	.1

¹ Based on Part B bills (physicians, outpatient services, home health agency services, and other suppliers of services) paid in 1979 through March 1980. Recipient counts and reimbursements correspond to a person's State of residence at the time the bill was processed which need not be the State which bought in for that person.

² No buy-in agreement; therefore the number of State buy-ins enrolled at any time is zero. It should be noted, however, that recipient counts and reimbursement counts are attributed to the person's State of residence at the time the bill was processed. The State of residence is not necessarily the State which bought in for that person.

SOURCE: Office of Statistics and Data Management, Bureau of Data Management and Strategy, HCFA, unpublished data.

TABLE 4.26
Medicaid Reimbursement Methods, by Type of Service and State, February 1982

Inpatient Hospital Services												
Alternative Reimbursement Systems ¹												
State	Medicare Principles	Methods Apply to Medicaid Only	Methods Apply to Medicaid and Private Payers	Methods Apply to All Payers	Outpatient Hospital Services		Long-Term Care ²			Physicians' Services		
					Medicare Principles	Other	SNF	ICF	ICF-MR	Medicare Principles (Percent under Prevailing Charge)	Fee Schedules	
											Fixed Fee Schedule	Relative Value Scale
Alabama		1981			X		PFS	PFS	<75			
Alaska ³	X				X		RFS	RFS	75			
Arkansas	X					X	PC	PC	<75			
California		1980				X	PC	PC			X	
Colorado		1974					PFS	PFS				
Connecticut	X					X	PFS	PFS				
Delaware	X				X		PFS	PFS	75			
District of Columbia	X				N/A	N/A	PFS	PFS	75		N/A	
Florida	X				X		PFS	PFS				
Georgia		1981			X		PFS	PFS	<75			
Hawaii	X						RFS	RFS	75			
Idaho		1980			X		PFS	PFS			X	
Illinois		1981				X	COM	COM			X	
Indiana	X				*	*	*	*			*	
Iowa	X				X		RFS	PFS	75			
Kansas	X				X		PFS	PFS	75			
Kentucky		1982			X		PFS	PFS	<75			
Louisiana	X				*	*	PC	PC	75			
Maine	X				X		RFS	RFS			X	
Maryland				1977 ⁴		X	RFS	RFS			X	
Massachusetts				1982 ⁴		X	RFS	RFS				
Michigan		1976			X		PFS	PFS	COM		X	
Minnesota	X				X		PFS	PFS	<75			
Mississippi		1981			X		PFS	PFS			X	
Missouri		1981			X		PFS	PFS			X	
Montana	X				X		PFS	PFS	<75			
Nebraska	X				*	*	PFS	PFS	<75			
Nevada	X				X		COM	COM	N/A		X	
New Hampshire	X						RFS	PFS			X	
New Jersey				1974 ⁴		X	PFS	PFS			X	

(continued)

TABLE 4.26 (continued)
Medicaid Reimbursement Methods, by Type of Service and State, February 1982

State	Inpatient Hospital Services									
	Alternative Reimbursement Systems ¹					Outpatient Hospital Services				
	Medicare Principles	Methods Apply to Medicaid Only	Methods Apply to Medicaid and Private Payers	Methods Apply to All Payers	Long-Term Care ²	Outpatient Hospital Services		Medicare Principles	Other	Physicians' Services
					SNF	ICF	ICF-MR	Medicare Principles (Percent under Prevailing Charge)	Fixed Fee Schedule	Relative Value Scale
New Mexico					RFS	RFS	RFS	<75		
New York		1970			PFS	PFS	PFS		X	
North Carolina		1981			COM	COM	COM		X	
North Dakota	X				COM	COM	COM	75		
Ohio	X				COM	COM	COM	<75		
Oklahoma	X				PC	PC	PC	75		
Oregon	X				PCF	PCF	RFS		X	
Pennsylvania	X				RFS	RFS	RFS		X	
Rhode Island	X		1974 ⁴		PFS	PFS	RFS		X	
South Carolina	X				PFS	PFS	RFS	<75		
South Dakota	X				PFS	PFS	PFS		X	
Tennessee	X				RFS	PFS	PFS	75		
Texas	X				PC	PC	PC		X	
Utah	X				COM	COM	COM	75		
Vermont	X				RFS	RFS	RFS	<75		
Virginia	X				PFS	PFS	RFS		X	
Washington	X				RFS	RFS	RFS		X	
West Virginia	X				RFS	RFS	RFS		X	
Wisconsin	X	1980			PFS	PFS	PFS	75		
Wyoming ⁵	X				PFS	PFS	PFS ₃	75		

¹ Year of implementation.

² N/A = Not available; N/C = not covered; PFS = Prospective, facility-specific; RFS = Retrospective, facility-specific; PCF = Prospective, class rate; COM = Combination of other methods.

³ State did not report.

⁴ Inpatient and outpatient payment schedules set by State through negotiation with hospitals and Blue Cross.

⁵ Wyoming does not provide ICF-MR services.

"—" Data not available.

SOURCE: Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982.

Section 2173 of the Omnibus Reconciliation Act of 1981 (OBRA-81). In its place, States were required only to provide assurances satisfactory to the Secretary that the rates paid to hospitals met acceptable standards of efficiency, quality, and access to care. (See Section J for a more detailed description of these standards.)

For all other services, States are free to choose their own method of payment as long as Medicaid payment levels do not exceed the amounts that would be paid under Medicare. As of February 1982, 33 States reported using Medicare principles for outpatient hospital services and 26 States reported Medicare principles for physicians' services. For SNF services and ICF services, States must ensure that their payment systems are reasonably related to cost. Use of a cost-related payment system for long-term care institutional services has been required by law since July 1, 1976, but became fully operational in different States at different times after that date. This cost-related requirement was altered by the Omnibus Reconciliation Act of 1980.

Federal regulations governing payments for prescription drugs, known as the maximum allowable cost (MAC) system, went into effect in August 1976. The MAC regulations place upper limits on government payments for certain "multisource" prescription drugs and require States to establish estimates of the acquisition costs (known as "estimated acquisition costs," or EAC) of all outpatient drug products prescribed for Medicaid enrollees. The exception to this regulation is that a physician may specify in writing that a higher cost drug is required. For Federal matching purposes, payments for prescription drugs may not exceed the MAC limit (plus a reasonable dispensing fee), the EAC estimate (plus a reasonable dispensing fee), or the provider's usual and customary charge to the general public—whichever is lowest.

2. State Administration, Training, and Provider Certification

Administration of State Medicaid programs is vested in single State agencies. Within each agency, State plans must designate a medical assistance unit responsible for developing, analyzing, and evaluating the Medicaid program. The law further requires the States to establish medical care advisory committees to counsel the Medicaid agency director about health and medical services. This committee must include board-certified physicians and other representatives of the health profession, members of consumer groups, and the director of either the State public welfare or the public health department (whichever department does not run the Medicaid agency).

Medicaid regulations establish certain standards governing personnel administration in State Medicaid programs. First, each State must employ a merit system of personnel administration. Second, the State plan must offer a training program for agency personnel. This program must include in-service training for new staff, be related to job duties, and be consistent with program objectives. Finally, the State plan must provide for the training and effective use of subprofessional staff and unpaid volunteers. Federal financial participation is available to States for administrative and training costs. Table 4.27 provides data on the Federal share of State payments for administration.

3. Provider Participation

Table 4.28 reports the number of participating providers and Medicaid certified beds in inpatient facilities, SNF's, ICF's and ICF/MR's. Providers are certified by each Medicaid program, whether or not they actually participate. The data in Table 4.28 are based on a special survey carried out in February 1982. States responding to the survey reported 222,078 participating physicians as of that date, along with 969,839 certified beds in general hospitals, 630,510 certified beds in SNF's, 651,993 in ICF's and 132,582 in ICF/MR's.

4. Eligibility Determination Level

States are allowed several options for administering mandatory coverage of SSI recipients:

- States electing to extend Medicaid to all SSI recipients can enter into an agreement with the Social Security Administration under Section 1634 of the Act for determinations of Medicaid eligibility. The Social Security Administration then provides States with eligibility information for the purpose of issuing Medicaid identification cards and maintaining State eligibility files for processing Medicaid claims;
- States electing to extend Medicaid eligibility to recipients of SSI can maintain eligibility determinations on a State level; or
- States electing the 209(b) option (where recipients of cash assistance under SSI are not automatically eligible for Medicaid) can require cash assistance recipients to make a separate application for Medicaid.

The option chosen by each State is listed in Table 4.29. As of February 1982, 29 States had elected Federal determination; 7 States had elected to extend Medicaid to all recipients of SSI but to maintain eligibility determination on a State level; and 14 had elected to retain their 209(b) status.

5. Medicaid Management Information System

The Social Security Amendments of 1972 authorized 90 percent Federal matching to States for the costs of design, development, and installation of mechanized claims processing and information retrieval systems, and 75 percent for the costs of operating such systems.

The Medicaid Management Information System (MMIS) is a general conceptual design that can be tailored by State Medicaid agencies to their own particular needs so long as the system meets Federally required minimum performance standards. The conceptual design includes six subsystems: recipient, provider, claims processing, reference file, surveillance and utilization review, and management and administration reporting. The first four subsystems work together with the overall objective of processing and paying each eligible provider for every valid claim. The other two subsystems consolidate and organize data necessary for managing and controlling the Medicaid program.

Table 4.29 summarizes current State progress in developing and implementing MMIS—type systems. Thirty-seven States, New York City and 3 upstate counties of New York have been approved for 75 percent Federal financial participation (FFP) for operation of a

TABLE 4.27

Federal Medicaid Expenditures for State Administration,
Fiscal Year 1980¹

State	Adjusted Federal Share (in millions)
Total U.S.	\$715.4
Alabama	5.9
Alaska	.9
Arkansas	5.0
California	106.0
Colorado	4.3
Connecticut	7.7
Delaware	1.3
District of Columbia	4.6
Florida	16.7
Georgia	12.1
Hawaii	2.3
Idaho	2.2
Illinois	28.6
Indiana	11.6
Iowa	5.4
Kansas	5.2
Kentucky	9.1
Louisiana	10.5
Maine	3.4
Maryland	9.5
Massachusetts	13.5
Michigan	40.4
Minnesota	13.2
Mississippi	5.4
Missouri	6.9
Montana	2.6
Nebraska	4.7
Nevada	1.7
New Hampshire	2.7
New Jersey	23.8
New Mexico	3.1
New York	135.4
North Carolina	12.5
North Dakota	2.5
Ohio	21.5
Oklahoma	14.1
Oregon	10.3
Pennsylvania	31.1
Rhode Island	3.0
South Carolina	6.2
South Dakota	1.5
Tennessee	6.6
Texas	51.9
Utah	3.8
Vermont	2.2
Virginia	9.1
Washington	12.9
West Virginia	3.5
Wisconsin	21.4
Wyoming	.4

¹ These figures represent each State's claims for administration and training and include prior period claims, collections, deferrals, disallowances, and suspensions taken by the regional office or paid in that fiscal year. These data are taken from Federal financial records and may differ from those reported on State expenditure claims.

SOURCE: Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982.

TABLE 4.28

Participating Physicians and Medicaid-Certified Providers and Beds, by Type of Provider and State, February 1982

State	Physicians		Beds Certified			
	Enrolled	Participating	General Hospital	Skilled Nursing Facility	Intermediate Care Facility	Intermediate Care Facility/ Mentally Retarded
Reporting Totals	405,835	222,078	969,839	630,510	651,993	132,582
Alabama	14,000	8,000	20,444 ¹	14,899 ¹	6,100 ¹	646 ¹
Alaska	473	N/A	926	146	316	126
Arkansas	5,608	4,000	12,327	9,845	9,870	2,159
California	61,503 ²	29,527 ²	106,105 ¹	107,308	4,534	9,055
Colorado	4,314 ³	3,771 ³	10,630	10,923	6,345	2,427
Connecticut	N/A	N/A	11,211	20,931	3,777 ⁴	*
Delaware	1,000	N/A	799	362	2,404	546
District of Columbia	1,842	1,441	4,779	87	1,633	65
Florida	48,143	7,874	43,211	33,107	34,138	2,046
Georgia	9,770 ⁵	4,944 ⁵	27,402	3,285	6,154	2,616
Hawaii	N/A	N/A	2,420	910	932	583
Idaho	920	680	2,763	4,295 ⁶	*	519
Illinois	22,929	16,007	61,339	46,180	44,685	10,408
Indiana	6,013	6,013	14,726	7,846	30,837	2,391
Iowa	4,054	3,254	20,586	1,425	30,392	1,846
Kansas	4,454 ⁹	1,447 ⁹	N/A	2,529 ⁹	22,610 ⁹	814 ⁹
Kentucky	6,283	3,603	15,024	3,973	13,758	1,367
Louisiana	6,746	7,800 ⁹	24,154	703	23,218	4,381
Maine	1,771 ³	1,138 ³	4,537	458	8,440	634
Maryland	7,222	4,668	15,090	7,986 ⁶	12,375	2,094
Massachusetts	13,848	N/A	27,498 ⁹	17,771 ⁹	26,493 ⁹	4,040 ⁹
Michigan	14,815 ³	9,170 ³	40,016	32,699	11,753	5,649
Minnesota	6,921	3,322	21,098	28,095	17,776	7,309
Mississippi	N/A	N/A	13,189	1,955	1,621 ⁷	1,314
Missouri	9,701	3,310	29,729	205	14,239	1,912
Montana	1,689	1,689	3,559	1,676	4,963	337
Nebraska	11,200 ⁵	11,200 ⁵	8,964	1,671	15,310	564
Nevada	900	750	3,501	0	340	187
New Hampshire	1,700	1,550 ⁵	3,156	625	6,025	342
New Jersey	15,320 ³	12,500 ³	33,000	27,452 ⁶	*	6,101
New Mexico	1,224	984	4,035	264	3,407	622
New York	N/A	N/A	N/A	69,725	25,870	17,510 ⁸
North Carolina	6,587 ⁹	2,652 ⁹	24,111	8,758 ⁹	11,318 ⁹	2,585 ⁹
North Dakota	1,618 ⁵	N/A	3,885	4,152	2,362	36
Ohio	21,065	13,444	55,519	277	27,119	5,300

(Continued)

TABLE 4.28 (continued)

Participating Physicians and Medicaid-Certified Providers and Beds, by Type of Provider and State, February 1982

State	Physicians		Beds Certified			
	Enrolled	Participating	General Hospital	Skilled Nursing Facility	Intermediate Care Facility	Intermediate Care Facility/ Mentally Retarded
Oklahoma	4,000	3,000	16,734	0	28,446	2,163
Oregon	3,168	3,168	8,050	2,253	10,956	2,131
Pennsylvania	17,264 ⁹	12,815 ⁹	85,459	72,387 ⁶	*	9,016
Rhode Island	1,365	1,365	3,437 ⁹	2,319 ⁹	6,689 ⁹	1,090 ⁹
South Carolina	4,967	2,087	15,094	6,994	3,785	2,376
South Dakota	675	N/A	3,693	3,149	3,810	785
Tennessee	8,360	4,113	26,733	226	32,578 ⁷	2,447
Texas	24,974	12,186	63,283	13,641	83,420	4,015
Utah	3,580	1,980	5,450	2,650	2,500	1,200
Vermont	N/A	450	1,957	739	2,349	436
Virginia	7,371	4,229 ⁵	22,669	1,752	18,724	3,733
Washington	4,300	4,116	13,263	23,217 ⁶	1,556	2,703
West Virginia	3,359	2,497	10,389	2,924 ⁶	3,117	156
Wisconsin	8,319 ⁵	4,884 ⁵	22,211	24,236	22,452	1,800
Wyoming	500	450	1,684	1,500	497	0

¹ Licensed bed; Medicaid certified beds not available.² Provider numbers, include solo physicians and group practices.³ 1980 Data.⁴ Includes ICF-MR beds.⁵ Includes out-of-state physicians.⁶ Includes ICF beds.⁷ Includes SNF/ICF beds.⁸ Includes Developmental Center beds.⁹ Revised estimate supplied by States.

N/A Not applicable.

* Denotes beds combined with another category.

SOURCE: Intergovernmental Health Policy Project Survey, February 1982.

TABLE 4.29

**Medicaid SSI Eligibility Determination and Status of State Medicaid
Management Information Systems, by Jurisdiction,
February 1982**

Medicaid Jurisdiction	SSI Eligibility Determination ¹			Medicaid Management Information System			
	Section 1634	State Determination	209(b) State	Certified	Certification Anticipated FY 82	Certification Implementation Plan	No MMIS
Alabama	X			X			
Alaska		X					X
Arkansas	X			X			
California	X			X			
Colorado		X		X			
Connecticut			X			X	
Delaware	X						X
District of Columbia	X				X		
Florida	X			X			
Georgia	X			X			
Hawaii			X	X			
Idaho		X		X			
Illinois			X		X		
Indiana			X	X			
Iowa	X			X			
Kansas		X		X			
Kentucky	X				X	X	
Louisiana	X			X			
Maine	X			X			
Maryland	X					X	
Massachusetts	X					X	
Michigan	X			X			
Minnesota			X	X			
Mississippi	X			X			
Missouri			X	X			
Montana	X			X			
Nebraska			X	X			
Nevada		X				X	
New Hampshire			X	X			
New Jersey	X			X			
New Mexico	X			X			
New York		X		X ²	X ²		
North Carolina			X	X			
North Dakota			X	X			
Ohio			X	X			

(Continued)

TABLE 4.29 (continued)

**Medicaid SSI Eligibility Determination and Status of State Medicaid
Management Information Systems, by Jurisdiction,
February 1982**

Medicaid Jurisdiction	SSI Eligibility Determination ¹			Medicaid Management Information System			
	Section 1634	State Determination	209(b) State	Certified	Certification Anticipated FY 82	Certification Implementation Plan	No MMIS
Oklahoma			X	X			
Oregon		X		X			
Pennsylvania	X			X			
Rhode Island	X						X
South Carolina	X			X			
South Dakota	X						
Tennessee	X			X			
Texas	X			X			
Utah			X	X			
Vermont	X			X			
Virginia			X	X			
Washington	X			X			
West Virginia	X			X			
Wisconsin	X			X			
Wyoming	X						X

¹ Eligibility determination for the territories is based on separate regulations and is found in 42 CFR 436. The Medicaid agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for OAA, AFDC, AB, APTD, or AABD.

² Certified: New York City and 3 upstate Pilot Counties. Anticipated Certification: 6 Upstate Regions.

SOURCES: Eligibility Determination — State Plans Branch, Bureau of Program Operations, HCFA; Medicaid Management Information Systems — Office of Methods and Systems, Bureau of Program Operations, HCFA.

mechanized claims processing and information retrieval system. Three States and 6 upstate regions of New York anticipate operation and approval of 75 percent FFP during Federal fiscal year 1982. Five States are currently in the planning, development, or installation phase, and four States have no active Federal MMIS plan. Current statutory authority for MMIS development is Public Law 92-603, Section 235, and Title 42 CFR 433 Subpart C, September 29, 1979.

6. Review for Fraud and Abuse

Under Federal law, a State plan must specify criteria and methods for identifying suspected fraudulent use of the Medicaid program, methods for investigating cases, and procedures for referring suspected fraud to law enforcement officials. The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1980 further authorize 90 percent FFP for the establishment and operation of Medicaid Fraud Control Units in the States.

These units must be a single identifiable entity located outside the Medicaid agency (for example, in the Office of the State's Attorney General). Fraud Control Units are responsible for investigating and prosecuting (or referring for prosecution) violations of State Medicaid laws, reviewing complaints alleging abuse or neglect of patients, recovering overpayments, and investigating recipient fraud. Staff of such units must include attorneys, auditors and investigators. To receive FFP at the 90 percent rate, the unit must be certified by the U.S. Department of Health and Human Services. At the end of 1979, 29 units with 803 investigators, auditors, and attorneys were certified.

Table 4.30 presents the results of State efforts to combat fraud and abuse during fiscal year 1980. Integrity reviews are initial reviews resulting from suspected fraud or abuse, which often result in the recovery of overpayments. Full scale investigations are expanded reviews typically involving questions of the medical necessity of care and requiring reviews by medical consultants, peer review committees, or Professional Standards Review Organizations (PSRO's). Sixty-five percent of all reported overpayment collections resulting from integrity reviews were generated by three States (Connecticut, Illinois, and New York). Two States (Illinois and New York) accounted for 78.6 percent of all collections resulting from full scale investigations.

H. Medicaid Data System

The majority of Medicaid data presented in this report come from a compilation of the annual and monthly Medicaid reports submitted by the State Title XIX Medicaid agencies on the HCFA-2082 and HCFA-120 reports. The States obtain this information from their own Medicaid claims processing and payment operations.

The major claims processing and payment system used in the States is the Medicaid Management Information System (MMIS). The General System Design (GSD) for these systems, completed and distributed in 1972, allowed for considerable variation in certain characteristics of the MMIS. This flexibility was and is congruent with the programmatic diversity existing across State programs. However, creating standardized reports

TABLE 4.30

Medicaid Provider Fraud and Abuse Activity, by Jurisdiction, Fiscal Year 1980

Medicaid Jurisdiction	Integrity Reviews			Full Scale Investigations		
	Number Completed FY 1980	Over- payments FY 1980	Number Pending End of FY 1980	Number Completed FY 1980	Over- payments FY 1980	Number Pending, End of FY 1980
All Reporting Jurisdiction	21,512	\$8,220,751	7,621	3,130	35,376,459	2,682
Alabama	924	5,397	82	79	22,015	17
Alaska	0	0	0	0	0	0
Arkansas	96	14,195	48	15	8,264	6
California	925	0	736	211	1,056,434	276
Colorado	62	53,234	6	11	26,316	0
Connecticut	1,667	1,554,210	0	22	133,446	2
Delaware	0	0	0	16	8,508	1
District of Columbia	14	0	2	2	0	5
Florida	36	290	94	45	135,766	30
Georgia	22	0	22	42	253,655	0
Hawaii	15	0	85	6	0	23
Idaho	97	953	3	19	71,706	3
Illinois	2,529	1,498,834	744	242	4,770,725	428
Indiana	1,258	0	253	17	48,816	2
Iowa	76	7,113	5	1	0	0
Kansas	1,456	0	0	206	172,964	176
Kentucky	338	47,089	14	8	707	4
Louisiana	128	18,802	57	64	24,092	31
Maine	53	14,651	13	15	53,153	8
Maryland	180	97,915	74	76	101,915	70
Massachusetts	1,707	575,479	2,447	400	1,846,073	0
Michigan	233	149,535	0	19	299,112	51
Minnesota	748	29,306	192	5	0	15
Mississippi	341	32,077	0	26	8,362	3
Missouri	258	0	234	59	35,147	7
Montana	38	0	16	3	34	2
Nebraska	29	0	2	5	0	11
Nevada	113	21,380	0	18	835	3
New Hampshire	186	30,956	7	47	15,411	58
New Jersey	1,977	1,520	0	479	1,255,776	709
New Mexico	46	0	59	25	83,553	18
New York	769	2,292,806	399	411	23,021,166	179
North Carolina	135	0	47	73	63,803	87
North Dakota	51	5,069	7	1	1,252	0
Ohio	2,411	198,279	922	96	1,019,762	124
Oklahoma	264	657	61	4	0	5
Oregon	289	257,605	89	99	65,240	16
Pennsylvania	654	5,823	248	43	70,428	88
Puerto Rico	4	0	0	5	0	0
Rhode Island	169	0	0	1	195,570	0
South Carolina	34	10,004	0	1	0	0
South Dakota	0	0	0	2	6,159	0
Tennessee	213	94,941	43	19	40,309	6
Texas	57	11,242	271	71	0	118
Utah	317	378,824	131	0	0	11
Vermont	95	0	4	11	1,072	5
Virginia	70	0	25	20	96,944	47
Washington	158	60,338	15	90	361,969	32
West Virginia	0	0	0	0	0	0
Wisconsin	270	752,227	164	0	0	5
Wyoming	0	0	0	0	0	0

SOURCE: Office of Program Validation, Bureau of Quality Control, HCFA.

out of systems employing non-standard coding, processing, and file structures is obviously problematic. Compounding these difficulties is the programmatic diversity inherent in Medicaid itself. For example, the considerable cross-county variation inherent in the New York State program leads to considerable problems in the creation of a State-level report. As a consequence of these and other factors, in any fiscal year approximately six States do not file an annual report, and in any month approximately two states do not file a monthly report. Historically, these missing reports have been estimated by using weighted linear extrapolation methods and aggregating data from other reports. It should be noted that on several occasions, information supplied by the States in subsequent years has been used to refine or correct previous missing years of data. Hence, data contained in this report may differ from those published previously.

J. Summary of Selected Medicaid Amendments of 1981

Several important changes were made in existing Medicaid law by the "Omnibus Budget Reconciliation Act of 1981." This Act (H.R. 3982) was adopted by the Senate and House on July 31, 1981, and signed into law (Public Law 97-35) by President Reagan on August 13. The present section summarizes the major changes in Medicaid law brought about by Title XXI, Subtitle C of Public Law 97-35, "Provisions Relating to Medicaid." Throughout this discussion, "prior law" is taken to mean those statutes and regulations in effect up to the time when the relevant sections of Public Law 97-35 became effective. All "section" references pertain to H.R. 3982, as amended and adopted by the Congress.

1. Changes in Payments to States

a) Reduction in Federal Matching Payments (Section 2161)

Under prior law, the Federal Government matched State Medicaid program expenditures at a percentage rate established by statutory formula. Public Law 97-35 does not change the basic matching formula, but does reduce the total Federal reimbursement each State will receive for the next 3 fiscal years. The reduction was 3 percent in FY 1982, will be 4 percent in FY 1983, and 4.5 percent in FY 1984. For each State, the specified reduction will be computed on the total Federal Medicaid reimbursement claimed by the State in that year (that is, total Medicaid expenditures times the basic Federal matching rate for the State). In each year, a State can lower its reduction rate by 1 percentage point for each of three conditions it is able to meet or that prevails: (1) operation of a qualified hospital cost review program; (2) an unemployment rate exceeding 150 percent of the national average; and (3) fraud and abuse recoveries (including third-party liability recoveries in FY 1982) equal to 1 percent of Federal payments to the State. To qualify under the first condition, a State's hospital cost review program must meet five criteria: (a) be established by statute, (b) be operated by the State, (c) review all non-Medicare inpatient revenues and expenses, including those under Medicare, (d) provide substantially equal treatment to all payers, and (e) demonstrate that its annual rate of increase in aggregate hospital costs

per capita or per admission is at least 2 percentage points lower than the rate of inflation in all States without qualifying programs.

In addition to those conditions, Section 2161 allows for a decrease in the designated reduction in Federal matching dollars for each State that keeps its spending levels within a "target" rate of growth. For FY 1982, the target level is set at 109 percent (that is, a 9 percent rate of growth) of each State's estimate of the Federal share of its FY 1981 spending level. (For this purpose, only estimates received by the Secretary before April 1, 1981, are valid.) For FY 1983 and FY 1984, target levels will be based upon changes in the medical care component of the consumer price index. In each year, \$1 will be deducted from a State's scheduled reduction in Federal matching funds for every dollar in State spending below the target level.

Reductions imposed by Section 2161 took effect on October 1, 1981 and applied to all existing Medicaid programs except Arizona²⁵ and the territories. All provisions under Section 2161 are repealed in FY 1985.

b) Payments to Territories (Section 2162)

Under prior law, annual Federal Medicaid payments to the territories could not exceed \$30 million for Puerto Rico, \$1 million for the Virgin Islands, and \$900 thousand for Guam. Effective October 1, 1982, Section 2162 establishes an annual ceiling of \$350 thousand for the Northern Mariana Islands, and increases the annual ceiling for Puerto Rico to \$45 million, the Virgin Islands to \$1.5 million, and Guam to \$1.4 million.

c) Other Changes in Payments to States

In addition to changes in FFP, Public Law 97-35 (1) eliminated the time limit on the period for which States must pay interest on disputed claims (Section 2163); (2) prohibited Federal matching payments for hospital tests provided to Medicaid recipients, unless such tests are specifically ordered by the attending physician or other responsible practitioners (Section 2164); (3) mandated that the Comptroller General study the feasibility and consequences of revising the Federal matching formula to take account of factors (other than State *per capita* income) that may affect the medical needs of Medicaid enrollees and the fiscal capacities of the States (Section 2165).

For more detailed information on the aforementioned Sections, the interested reader is referred to the Code of Federal Regulations, Title 42, 1981.

²⁵See footnote 5.

2. Increased Flexibility for States

In addition to changes in Medicaid financing and reimbursement provisions, Public Law 97-35 also increased State discretion in the following areas of Medicaid program policy:

- Coverage of, and Services for the Medically Needy (Section 2171);
- Coverage of Individuals Aged 18-20 (Section 2172);
- Reimbursement of Hospitals (Section 2173);
- Medicaid Reasonable Charge Limitations (Section 2174);
- Freedom-of-Choice and Other State Plan Requirements (Section 2175);
- Home and Community-Based Services (Section 2176);
- Requests for Plan Amendments and Waivers (Section 2177);
- Prepaid Provider (HMO) Participation in State Plans (Section 2178);
- EPSDT Penalty (Section 2181);
- Collection of Third-Party Payments (Section 2182);
- Recertifications by Physician Assistants and Nurse Practitioners (Section 2183).

a) Coverage of, and Services for the Medically Needy (Section 2171)

Under prior law, if a State chose to cover the medically needy it was required to extend such coverage to all medically needy groups, to provide services that were comparable in amount, duration, and scope to all such groups; and to offer a minimum number of services, including a mix of institutional and non-institutional services. Section 2171 repeals most existing coverage and service requirements regarding the medically needy (except that States must continue to offer HHA services to anyone eligible for SNF care) and establishes three minimum requirements for States that elect to cover any medically needy groups:

- The State must provide ambulatory services to children, and prenatal and delivery services for pregnant women;
- groups covered for institutional services must also be covered for ambulatory services;
- if ICF/MR or psychiatric hospital services are covered for any group, then the current mandatory services, or seven services from the entire list, also must be covered for that group.

Additionally, States electing to provide coverage to medically-needy groups must describe in their State Plans the criteria used to determine eligibility for such groups and the amount, duration, and scope of services made available to each. Section 2171 takes effect upon enactment of the legislation.

b) Flexibility in Coverage of Individuals Aged 18-20 (Section 2172)

Under prior law, States were required to provide Medicaid coverage to anyone under 21 who could qualify for AFDC if they met the age or school attendance requirement for AFDC. Section 2172 drops this requirement and makes coverage of such individuals a State option. States may limit such coverage to children under 21, 20, 19, or 18, or any reasonable category of such children. Section 2172 took effect August 13, 1981 (the day Public Law 97-35 was signed).

c) Reimbursement of Hospitals (Section 2173)

Under prior law, State Medicaid programs were required to pay for inpatient hospital services on a Medicare "reasonable cost" basis, unless the Secretary of DHHS approved an alternate reimbursement method. Section 2173 drops this provision, but requires assurances satisfactory to the Secretary that the rates paid to hospitals—

- are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards;
- take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, which serve large numbers of low income patients;
- provide reasonable access to inpatient hospital services of adequate quality;
- are routinely documented through uniform cost reports filed by each hospital and through periodic audits by the States of such reports. These provisions apply to services furnished on or after the date final regulations are promulgated to carry out Section 2173.

Section 2173 also requires the Secretary to develop a model prospective payment methodology for inpatient hospital costs which could be used under both the Medicare and Medicaid programs.

d) Removal of Medicaid Reasonable Charge Limitation (Section 2174)

Under prior law, State Medicaid payments for physicians' services and certain medical supplies and laboratory services could not exceed reasonable charge levels established under Medicare. Additionally, State Plans were required to provide for methods and procedures to assure that payments under the State Plan do not exceed reasonable charges. Effective October 1, 1981, Section 2174 repeals both requirements.

e) Inapplicability and Waiver of Freedom-of-Choice and Other State Plan Requirements (Section 2175)

Under prior law, Medicaid eligibles were free to choose any provider, practitioner, or supplier of health services covered by a State's Medicaid program. The Secretary was authorized to waive any Federal Medicaid requirements to enable States to conduct experimental, pilot, or demonstration projects, including prospective reimbursement demonstration. No time limit was set on Secretarial action on State waiver requests. In order to provide States more flexibility in implementing various cost saving measures, Section 2175 provides that a State shall not be held out of compliance for failure to meet certain State Plan requirements (for example, Statewideness, freedom-of-choice), if it:

- purchases laboratory services and medical devices through a competitive arrangement, and the Secretary finds that adequate services or devices were available to beneficiaries. (Laboratories selected to provide services must meet designated quality standards and do no more than 75 percent of their total business with Medicaid and Medicare);

- contracts with organizations which agree to provide services in addition to those offered under the State Plan to eligible individuals residing in the area served by the organization and who elect to receive care from the organization;
- pays only for rural health clinic services;
- "locks-in" beneficiaries who overutilize services to a particular provider for a reasonable time period; or
- "locks-out" providers who abuse the program, subject to prior notice and opportunity for a hearing and provided that eligible individuals have reasonable access to services of adequate quality.

Additionally, Section 2175 authorizes the Secretary to waive certain existing Medicaid requirements to assist States in improving cost-effectiveness in various areas of program operation. Specifically, Section 2175—

- allows States to create a primary care case management system or a physician specialty arrangement;
- allows a locality to act as a central broker in assisting Medicaid beneficiaries in selecting among competing health plans;
- permits States to share with recipients (in the form of additional services) savings resulting from use of more cost-effective care;
- restricts the provider from whom recipients can obtain services (in other than emergency situations) to those who agree to comply with reasonable State standards.

Section 2175 waivers may not extend beyond 2 years unless the State requests a continuation. A continuation will be deemed granted unless the Secretary denies the State's request in writing within 90 days after the date it is submitted to the Secretary. The Secretary must monitor authorized waivers to assure compliance and terminate any waiver (after prior notice and opportunity for a hearing) when noncompliance is found. Section 2175 is effective for calendar quarters beginning on or after October 1, 1981. (Where the Secretary determines that additional State legislation is required for the State Plan to meet the standards that apply to the provision of laboratory services under Section 2175, the State will not be considered to be out of compliance until January 1 of the year following the close of the first regular session of the State legislature that begins after the date of enactment).

f) Waiver to Provide Home and Community-Based Services for Certain Individuals (Section 2176)

Under prior law, Federal matching assistance was available only for "medical" services. Section 2176 authorizes the Secretary to waive this limitation in the case of certain home or community-based services as a way of encouraging long-term care patients to receive care in less costly noninstitutional settings. Specifically, Section 2176 Waivers allow States to include under their Medicaid State Plan approved home or community-based services (except room and board) to individuals who, without these services, would require care in an SNF or ICF which would be paid for under the State Plan. The new law identifies seven specific services.

- case management
- homemaker services
- home health aide services
- personal care services
- adult day health services
- habilitation services
- respite care

In addition, the Secretary may approve "other" services requested by the State. In order to receive a waiver, States must provide assurances that:

- necessary safeguards have been taken pertaining to beneficiaries' health and welfare and to account for funds expended on these services;
- the need for such services by those entitled to SNF or ICF care will be evaluated;
- individuals determined likely to require SNF or ICF care are informed of these alternative services;
- the estimated average *per capita* expenditure for all services provided individuals under this waiver will not exceed what would have been spent for those persons without the waiver;
- they will provide information annually to the Secretary on the impact of the waiver.

Section 2176 also authorizes the Secretary to waive previous requirements that services must be (1) provided Statewide, and (2) equal in amount, duration, and scope for all comparable groups. Waivers initially will be granted for a 3-year period, and may be extended for additional 3-year periods, upon State request, unless the Secretary determines that the State's assurances have not been met. Section 2176 took effect 90 days after Public Law 97-35 was enacted.

g) Time Limitation for Action on Requests for Plan Amendments and Waivers (Section 2177)

Prior law required the Secretary of DHHS to approve all State Medicaid plans, plan amendments, and waivers; however, no time-limit on Secretarial action was established. Section 2177 sets a time limit of 90 days for the Secretary to act on requests for proposed Medicaid Plans, plan amendments, and waivers. Such requests are deemed granted, unless the Secretary either denies them or requests further information within 90 days of the date of submission. The Secretary has 90 days to act after the date additional information is received. Section 2177 took effect 90 days after Public Law 97-35 was enacted.

h) Flexibility in Prepaid Provider (HMO) Participation in State Plans (Section 2178)

Under prior law, States could enter into prepaid risk contracts only with Federally qualified HMO's. Contracting HMO's were further required to have an enrollment consisting of less than 50 percent Medicaid and Medicare beneficiaries. In addition to qualified HMO's, Section 2178 allows States to enter into prepaid risk contracts with organizations which (1) make covered services accessible to Medicare enrollees to the same extent that these services are accessible to Medicaid recipients not enrolled with the organization, and (2) have made adequate provision against the risk of insolvency. (Participating organizations also must assure that Medicaid enrollees will not be held liable for debts in the event of the organization's insolvency.) Additionally, these contracts must provide for:

- Secretarial and State access to certain books and records of the HMO's;
- Non-discrimination on the basis of health status or use of health services in the entity's enrollment, reenrollment and disenrollment activities;

- Disenrollment rights for individuals after one full month of membership;
- Reimbursement for medically necessary services (received under certain circumstances) out of plan.

Section 2178 also (1) requires States to continue Medicaid eligibility to the end of an HMO's minimum enrollment period for Medicaid-covered HMO enrollees who would otherwise lose their Medicaid eligibility, (2) raises the previous enrollment limit from no more than 50 percent to no more than 75 percent Medicare and Medicaid beneficiaries, and (3) allows the Secretary to modify or waive the latter requirement for public HMO's, where warranted by special circumstances and where the HMO is making reasonable efforts to enroll individuals from the private sector. Section 2178 took effect on October 1, 1981, for services furnished on or after that date. The amendments do not apply to contracts entered into before that date, unless the HMO, the State, and the Secretary agree.

i) Repeal of EPSDT Penalty (Section 2181)

Prior law required a 1-percent reduction in Federal matching payments to a State for AFDC administrative expenses for failure (1) to inform AFDC families of the availability of EPSDT services under Medicaid, (2) to provide or arrange for screening services when requested, or (3) to arrange for corrective treatment of conditions identified by child health screening services. Section 2181 repeals these AFDC penalty provisions effective back to June 30, 1974. In their place, State Medicaid Plans must now provide for informing all Medicaid eligibles under 21 years of age of the availability of EPSDT services and for arranging for screening and treatment services.

j) Flexibility in Requiring Collection of Third-Party Payments (Section 2182)

Under prior law, States were required to recover payments due for services provided to Medicaid eligibles through private insurance or other third-party coverage. As of October 1, 1981, Section 2181 exempts States from collecting third-party liabilities in cases where the amount the State can reasonably be expected to collect is less than the costs of recovery.

k) Permitting Physician Assistants and Nurse Practitioners to Provide Certain Recertifications (Section 2183)

Before OBRA-81, States were subject to a fiscal penalty unless physicians certified (and recertified every 60 days) the need for institutional services for Medicaid eligibles in a hospital, SNF, or ICF. Section 2183 allows States to use physician assistants and nurse practitioners (within the scope of their practice under State law) supervised by a physician to recertify the need for care. It also changes the time period for certification and recertification for individuals in ICF/MR's from 60 days to once a year. The new provisions apply to payments made to States for the calendar quarter beginning on or after October 1, 1981.

References

- Fisher, Charles R. "Differences by Age Groups in Health Care Spending." *Health Care Financing Review*, Volume 1, Issue 4, Pub. No. 03045, Spring 1980.
- Gibson, Robert M. and Daniel R. Waldo. "National Health Expenditures, 1981," *Health Care Financing Review*, Volume 4, No. 1, Pub. No. 03148, September 1982.
- Gornick, Marian, "Trends and Regional Variations in Hospital Use Under Medicare." *Health Care Financing Review*, Volume 3, Issue 3, Pub. No. 03141, March 1982.
- Muse, Donald. *National Annual Medicaid Statistics: Fiscal Years 1973 through 1979*. Health Care Financing Administration, Pub. No. 03133, August 1982.
- Muse, D. and D. Sawyer. *The Medicare and Medicaid Data Book, 1981*. Health Care Financing Administration, Pub. No. 03128, April 1982.
- National HMO Census, 1981*. Department of Health and Human Services, Public Health Service, Rockville, Maryland 20857. Pub. No. 82-50177, 1982.
- Ruther, M. and A. Dobson. "Equal Treatment and Unequal Benefits: A Re-examination of the Use of Medicare Services by Race, 1967-1976." *Health Care Financing Review*, Volume 2, Issue 3, Pub. No. 03090, Winter 1981.

Appendix 1

Medicare Carriers and Intermediaries

A. Blue Cross Associations and Blue Cross Plans

Blue Cross and Blue Shield
Associations
676 North St. Clair Street
Chicago, Illinois 60611

Blue Cross and Blue Shield of
Alabama
450 Riverchase Parkway
Birmingham, Alabama 35298

Alaska—See Blue Cross of
Washington/Alaska

Blue Cross and Blue Shield of
Arizona, Inc.
2444 W. Las Palmaritas Drive
Phoenix, Arizona 85021

Mailing address:
P.O. Box 13466
Phoenix, Arizona 85002

Arkansas Blue Cross and Blue
Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

Blue Cross of California—Southern
Division
21555 Oxnard Street
Woodland Hills, California 91470

Mailing address:
P.O. Box 7000
Van Nuys, California 91470

Blue Cross of California—Northern
Division
1950 Franklin Street
Oakland, California 94659

Rocky Mountain Hospital and
Medical Service
(d/b/a Blue Cross/Blue Shield of
Colorado)
700 Broadway
Denver, Colorado 80273

Blue Cross and Blue Shield of
Connecticut, Inc.
370 Bassett Road
North Haven, Connecticut 06473

Blue Cross of Delaware, Inc.
201 West Fourteenth Street
Wilmington, Delaware 19899

Group Hospitalization, Inc.
550 Twelfth Street, S.W.
Washington, D.C. 20024

Blue Cross and Blue Shield of
Florida, Inc.
P.O. Box 1798
Jacksonville, Florida 32201

Blue Cross/Blue Shield of Georgia/
Atlanta, Inc.
3348 Peachtree Road, N.E.
P.O. Box 4445
Atlanta, Georgia 30302

Blue Cross of Georgia/Columbus,
Inc.
2357 Warm Springs Road
P.O. Box 7368
Columbus, Georgia 31908

Blue Cross of Idaho Health Service,
Inc.
1501 Federal Way
P.O. Box 7408
Boise, Idaho 83707

Health Care Service Corp.
233 North Michigan Avenue
Chicago, Illinois 60601

Mutual Hospital Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Blue Cross of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Cross of Western Iowa and
South Dakota
Hamilton Blvd. and I-29
Sioux City, Iowa 51102

Blue Cross of Kansas, Inc.
1133 Topeka Blvd.
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of
Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40223

Louisiana Health Service and
Indemnity Company
2718A Wooddale Blvd.
Baton Rouge, Louisiana 70805

Associated Hospital Service of
Maine
(d/b/a Main Blue Cross/Blue Shield)
110 Free Street
Portland, Maine 04101

Blue Cross of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Cross of Massachusetts
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of
Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of
Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Cross and Blue Shield of
Mississippi, Inc.
P.O. Box 1043
Jackson, Mississippi 39205

Blue Cross Hospital Service, Inc.
of Missouri
4444 Forest Park
St. Louis, Missouri 63108

Blue Cross of Montana
3360 10th Avenue, South
P.O. Box 5017
Great Falls, Montana 59403

Blue Cross and Blue Shield of
Nebraska
P.O. Box 3248
Main Post Office Station
Omaha, Nebraska 68180

New Hampshire-Vermont Health
Service, Inc.
Two Pillsbury Street
Concord, New Hampshire 03301

A. Blue Cross Associations and Blue Cross Plans (continued)

Hospital Service Plan of New Jersey
33 Washington Street
Newark, New Jersey 07102

New Mexico Blue Cross and Blue
Shield, Inc.
12800 Indian School Road, N.E.
Albuquerque, New Mexico 87112

Blue Cross and Blue Shield of
Greater New York
622 Third Avenue
New York, New York 10017

Blue Cross and Blue Shield of
North Carolina
P.O. Box 2291
Durham, North Carolina 27702

Blue Cross of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121

Hospital Care Corporation
1351 William Howard Taft Road
Cincinnati, Ohio 45206

Blue Cross of Northeast Ohio
2066 East Ninth Street
Cleveland, Ohio 44115

Blue Cross of Central Ohio
255 East Main
P.O. Box 16526
Columbus, Ohio 43216

Blue Cross of Northwest Ohio
P.O. Box 943
Toledo, Ohio 43656

Blue Cross & Blue Shield of
Oklahoma
1215 South Boulder Avenue
Tulsa, Oklahoma 74119

Northwest Hospital Service
(d/b/a Blue Cross of Oregon)
100 S.W. Market Street
P.O. Box 1271
Portland, Oregon 97201

Blue Cross of Lehigh Valley
1221 Hamilton Street
Allentown, Pennsylvania 18102

Capital Blue Cross
100 Pine Street
Harrisburg, Pennsylvania 17101

Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Blue Cross of Western Pennsylvania
One Smithfield Street
Pittsburgh, Pennsylvania 15222

Blue Cross of Northeastern
Pennsylvania
Blue Cross Building
70 North Main Street
Wilkes Barre, Pennsylvania 18711

Blue Cross of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of
South Carolina
Columbia, South Carolina 29219

South Dakota—See Blue Cross of
Western Iowa and South Dakota

Blue Cross and Blue Shield of
Tennessee
Blue Cross Building
Chattanooga, Tennessee 37402

Group Hospital Service, Inc.
P.O. Box 222146
Dallas, Texas 75222

Blue Cross of Utah
2455 Parley's Way
P.O. Box 30270—Medicare A
Salt Lake City, Utah 84130

Blue Cross of Virginia
2015 Staples Mill Road
P.O. Box 27401
Richmond, Virginia 23279

Blue Cross of Southwestern Virginia
P.O. Box 13047
602 South Jefferson Street
Roanoke, Virginia 24045

Blue Cross of Washington and
Alaska
15700 Dayton Avenue, North
P.O. Box 327
Seattle, Washington 98111

Blue Cross Hospital Service, Inc.
P.O. Box 1353
City Center West
Charleston, West Virginia 25325

Blue Cross/Blue Shield United of
Wisconsin
401 West Michigan Street
P.O. Box 2025
Milwaukee, Wisconsin 53201

Blue Cross and Blue Shield of
Wyoming
4000 House Avenue
P.O. Box 2266
Cheyenne, Wyoming 82001

B. Blue Shield Plans

Blue Cross & Blue Shield of Alabama
450 Riverchase Parkway
Birmingham, Alabama 35298

Arkansas Blue Cross and Blue
Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

California Physicians Service
(d/b/a Blue Shield of California)
No. 2 Northpoint
San Francisco, California 94120

Mailing address:
P.O. Box 7968-Rincon Annex 94120

Rocky Mountain Hospital and
Medical Service
(d/b/a Blue Cross and Blue Shield
of Colorado)
700 Broadway
Denver, Colorado 80273

Delaware—See Pennsylvania Blue
Shield

District of Columbia—See
Pennsylvania Blue Shield

Blue Cross & Blue Shield of Florida,
Inc.
P.O. Box 1798
Jacksonville, Florida 32201

Mutual Medical Insurance, Inc.
Medicare Department
120 West Market Street
Indianapolis, Indiana 46204

Blue Shield of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Shield of Kansas, Inc.
P.O. Box 239
1133 Topeka Blvd.
Topeka, Kansas 66601

Blue Cross and Blue Shield of
Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40233

Blue Shield of Maryland, Inc.
700 East Joppa road
Towson, Maryland 21204

Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of
Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of
Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Montana Physicians' Service
P.O. Box 4310
404 Fuller Avenue
Helena, Montana 59601

New Hampshire-Vermont Health
Service
Two Pillsbury Street
Concord, New Hampshire 03301

Blue Shield of Western New York,
Inc.
298 Main Street
Buffalo, New York 14202

Blue Cross & Blue Shield of Greater
New York
622 Third Avenue
New York, New York 10017

Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121

Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, Pennsylvania 17011

Seguros de Servicio de Salud de
Puerto Rico, Inc.
GPO Box 3628
San Juan, Puerto Rico 00936

Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross & Blue Shield of South
Carolina
Columbia, South Carolina 29219

South Dakota—See Blue Shield of
North Dakota

Group Medical & Surgical Service
P.O. Box 222147
Dallas, Texas 75222

Blue Cross & Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270—Medicare B
Salt Lake City, Utah 84130

New Hampshire-Vermont Health
Service
Two Pillsbury Street
Concord, New Hampshire 03301

Washington Physicians Service
4th & Battery Building
6th Floor
2401 4th Avenue
Seattle, Washington 98121

Wisconsin Physicians' Service
Insurance Corporation
1717 West Broadway
Monoma, Wisconsin 53713

C. Commercials, Independent, State, and Other

Aetna Life & Casualty
151 Farmington Avenue
Hartford, Connecticut 06156

Connecticut General Life Insurance
Company
900 Cottage Grove Road
Bloomfield, Connecticut 06002

Mailing Address:
Hartford, Connecticut 06152

Cooperative de Seguros de Vida
de Puerto Rico
GPO Box 3428
San Juan, Puerto Rico 00936

E.D.S. Federal Corporation
7171 Forest Lane
Dallas, Texas 75230

The Equitable Life Assurance
Society of the United States
1285 Avenue of the Americas
New York, New York 10019

General American Life Insurance
Company
13045 Tesson Ferry Road
St. Louis County, Missouri 63128

Group Health, Inc.
30 West 42nd Street
New York, New York 10036

Hawaii Medical Service Association
1504 Kapiolani Boulevard
P.O. Box 860
Honolulu, Hawaii 96808

Kaiser Foundation Health Plan, Inc.
1956 Webster Street
Room 310-A
Oakland, California 94612

Mutual of Omaha Insurance
Company
P.O. Box 456
Downtown Station
Omaha, Nebraska 68101

Nationwide Mutual Insurance
Company
P.O. Box 1625
Columbus, Ohio 43216

Department of Human Services
101 Sequoyah Building
Oklahoma City, Oklahoma 73105

Pan-American Life Insurance
Company
Pan-American Life Center
P.O. Box 60450
601 Poydras Street
New Orleans, Louisiana 70130

The Prudential Insurance Company
of America
Drawer 471
Millville, New Jersey 08332

Transamerica Occidental Life
Insurance Company
12th at Hill Street
Los Angeles, California 90054

Mailing address:
P.O. Box 54905
Terminal Annex

The Travelers Insurance Company
One Tower Square
Hartford, Connecticut 06115

Office of Direct Reimbursement
1-F-1 Equitable Building
Room 1705
Baltimore, Maryland 21235

Railroad Retirement Board
844 Rush Street
Chicago, Illinois 60611

NOTE: d/b/a means "doing
business as"

Appendix 2

Medicaid Agencies and Fiscal Agents

A. Single State Agencies and State Medical Assistance Units

Alabama (region IV):
Single State Agency and Medical Assistance Unit:
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, Alabama 36130
205 277-2710

Alaska (region X):
Single State Agency:
Department of Health and Social Services
Pouch H-01
Juneau, Alaska 99811
907 465-3030

Medical Assistance Unit:
Division of Public Assistance
Department of Health and Social Services
Pouch H-07
Juneau, Alaska 99811
907 465-3355

Arkansas (region VI):
Single State Agency:
Department of Human Services
Seventh and Main Donaghey Building, Room 1428
Little Rock, Arkansas 72201
501 371-1001

Medical Assistance Unit:
Office of Medical Services
Division of Social Services
Department of Human Services
P.O. Box 1437
Little Rock, Arkansas 72203
501 371-1806

California (region IX):
Single State Agency:
Department of Health Services
714 P Street—Room 1253
Sacramento, California 95814
916 445-1248

Medical Assistance Unit:
Assistant Director
State Dept. of Health Services
714 P Street
Sacramento, California 95814
916 445-1351

Colorado (region VII):
Single State Agency:
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203
303 866-3041

Medical Assistance Unit:
Division of Medical Assistance
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203
303 866-3031

Connecticut (region I):
Single State Agency:
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2008

Medical Assistance Unit:
Medical Care Administration
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-4120

Delaware (region III):
Single State Agency:
Department of Health and Social Services
Delaware State Hospital
New Castle, Delaware 19720
302 421-6705

Medical Assistance Unit:
Medical Assistance
Department of Health and Social Services
Division of Economic Services
P.O. Box 906
New Castle, Delaware 19720
302 421-6139

District of Columbia (region III):
Single State Agency:
Dept. of Human Services
801 North Capitol Street, N.E.
Washington, D.C. 20002
202 727-0310

Medical Assistance Unit:
Office of Health Care Financing
Room 500
1331 H Street, N.W.
Washington, D.C. 20005
202 727-0735

Florida (region IV):
Single State Agency:
Department of Health and Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301
904 488-7721

Medical Assistance Unit:
Office of Medicaid
Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Florida 32301
904 488-3560

Georgia (region IV):
Single State Agency:
Georgia Department of Medical Assistance
1010 West Peachtree Street, N.W.
Atlanta, Georgia 30309
404 894-4911

Medical Assistance Unit:
Department of Medical Assistance
1010 West Peachtree St., N.W.
Atlanta, Georgia 30309
404 894-4911

Guam (region IX):
Single State Agency:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910
Overseas Operator: 734-9901

Medical Assistance Unit:
Medical Care Service
Department of Public Health and Social Services
P.O. Box 2719
Agana, Guam 96910
Overseas Operator: 734-9901

Hawaii (region IX):
Single State Agency:
Department of Social Services
and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6260

Medical Assistance Unit:
Medical Care Administration
Department of Social Services
and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6584

Idaho (region X):
Single State Agency:
Department of Health and
Welfare
Statehouse
Boise, Idaho 83720
208 334-4322

Medical Assistance Unit:
Medical Assistance Section
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-4323

Illinois (region V):
Single State Agency:
Illinois Dept. of Public Aid
316 South Second Street
Springfield, Illinois 62762
217 782-6716

Medical Assistance Unit:
Division of Medical Program
Services
931 E. Washington Street
Springfield, Illinois 62763
217 782-0506

Indiana (region V):
Single State Agency:
Indiana Dept. of Public Welfare
State Office Building
100 North Senate Ave.
Room 701
Indianapolis, Indiana 46204
317 232-4705

Medical Assistance Unit:
Assistant Administrator—
Medicaid
State Dept. of Public Welfare
100 North Senate Ave.—Room 701
Indianapolis, Indiana 46204
317 633-5582

Iowa (region VII):
Single State Agency:
Department of Social Services
Hoover State Office Building,
5th Floor
Des Moines, Iowa 50319
515 281-5452

Medical Assistance Unit:
Medical Services Section
Dept. of Social Services
Hoover State Office Bldg.—5th Fl.
Des Moines, Iowa 50319
515 281-5452

Kansas (region VII):
Single State Agency:
Dept. of Social Rehabilitation
Service
State Office Bldg.
Topeka, Kansas 66612
913 296-3271

Medical Assistance Unit:
Division of Medical Programs
Dept. of Social and Rehabilitation
Service
State Office Bldg.
Topeka, Kansas 66612
913 296-3981

Kentucky (region IV):
Single State Agency:
Dept. of Social Insurance
Cabinet for Human Resources
275 East Main Street
Frankfort, Kentucky 40621
502 564-3703

Medical Assistance Unit:
Division for Medical Assistance
Dept. of Social Insurance
Cabinet for Human Resources
275 East Main Street
Frankfort, Kentucky 40621
502 564-4321

Louisiana (region VI):
Single State Agency:
Louisiana Dept. of Health and
Human Resources
P.O. Box 3776
Baton Rouge, Louisiana 70821
504 342-6711

Medical Assistance Unit:
Medical Assistance Program
Administration
Office of Family Security
P.O. Box 44065
Baton Rouge, Louisiana 70804
504 342-3891

Maine (region I):
Single State Agency:
Dept. of Human Services
Statehouse
Augusta, Maine 04333
207 289-2736

Medical Assistance Unit:
Bureau of Medical Services
Dept. of Human Services
Statehouse
Augusta, Maine 04333
207 289-2674

Maryland (region III):
Single State Agency:
Department of Health and
Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301 383-2600

Medical Assistance Unit:
Medical Care Program
Dept. of Health and Mental
Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301 383-6327

Massachusetts (region I):
Single State Agency:
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617 727-6190

Massachusetts Commission for
the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5580

Medical Assistance Unit:
Medical Assistance
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617 727-6095/3907

Medical Assistance:
Massachusetts Commission for
the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5590

Michigan (region V):
Single State Agency:
Michigan Department of Social
Services
Commerce Center Building
P.O. Box 30037
Lansing, Michigan 48909
517 373-2000

Medical Assistance Unit:
Medical Services Administration
Department of Social Services
921 West Holmes Road
P.O. Box 30037
Lansing, Michigan 48909
517 373-8168

Minnesota (region V):
Single State Agency:
Department of Public Welfare
Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
612 296-2701

Medical Assistance Unit:
Medical Assistance Program
Bureau of Income Maintenance
Dept. of Public Welfare
444 La Fayette Road
P.O. Box 43170
Saint Paul, Minnesota 55164

Mississippi (region IV):
Single State Agency and Medical
Assistance Unit:
Mississippi Medical
Commission
4785 I-55 North
P.O. Box 16786
Jackson, Mississippi 39206
601 354-7464

Missouri (region VII):
Single State Agency:
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65101
314 751-4815

Medical Assistance Unit:
Division of Family Services
Department State Office Building
Broadway State Office Building
Jefferson City, Missouri 65101
314 751-2500

Montana (region VII):
Single State Agency:
Department of Social and
Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601
406 449-5622

Medical Assistance Unit:
Medical Assistance Bureau
Economic Assistance Division
Department of Social and
Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601
406 449-3952

Nebraska (region VII):
Single State Agency:
Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
401 471-3121

Medical Assistance Unit:
Medical Service Division
Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402 471-3121

Nevada (region IX):
Single State Agency:
Department of Human
Resources
Kinkead Building—Capital
Complex
505 East King Street
Carson City, Nevada 89710
702 885-4730

Medical Assistance Unit:
Medical Care Section (Title XIX)
Welfare Division
Department of Human Resources
251 Jeanell Drive
Capitol Complex
Carson City, Nevada 89710
702 885-4775

New Hampshire (region I):
Single State Agency:
Department of Health and
Welfare
Hazen Drive
Concord, New Hampshire 03301
603 271-4331

Medical Assistance Unit:
Office of Medical Services
New Hampshire Division of
Welfare
Hazen Drive
Concord, New Hampshire 03301
603 271-4353

New Jersey (region II):
Single State Agency:
Department of Human Services
Capitol Place One
Trenton, New Jersey 08625
609 292-3717

Medical Assistance Unit:
Division of Medical Assistance
and Health Services
Department of Human Services
324 East State Street
Trenton, New Jersey 08625
609 292-7244

New Mexico (region VI):
Single State Agency:
Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-2371

Medical Assistance Unit:
Medical Assistance Bureau
Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-5551

New York (region II):
Single State Agency:
State Dept. of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9475

Medical Assistance Unit:
Division of Medical Assistance
State Dept. of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9132

North Carolina (region IV):
Single State Agency:
Dept. of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919 733-4534

Medical Assistance Unit:
Division of Medical Assistance
Dept. of Human Resources
410 N. Boylon Avenue
Raleigh, North Carolina 27603
919 733-2060

North Dakota (region VIII):
Single State Agency:
Social Service Board of North
Dakota
State Capitol Building
Bismarck, North Dakota 58505
701 224-2310

Medical Assistance Unit:
Medical Service
Social Service Board of North
Dakota
State Capitol Building
Bismarck, North Dakota 58505
701 224-2321

Ohio (region V):
Single State Agency:
Dept. of Public Welfare
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215
614 466-6282

Medical Assistance Unit:
Division of Medical Assistance
Dept. of Public Welfare
30 East Broad Street, 31st Floor
Columbus, Ohio 43215
614 466-2365

Oklahoma (region VI):
Single State Agency:
Dept. of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3646

Medical Assistance Unit:
Medical Services Administration
Dept. of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3801

Oregon (region X):
Single State Agency:
Dept. of Human Resources
318 Public Service Building
Salem, Oregon 97310
503 278-3034

Medical Assistance Unit:
Adult and Family Services Division
Dept. of Human Resources
203 Public Service Building
Salem, Oregon 97310
503 378-2263

Pennsylvania (region III):
Single State Agency:
State Dept. of Public Welfare
Health and Welfare Building
Harrisburg, Pennsylvania 17120
717 787-2600/3600

Medical Assistance Unit:
Office of Medical Assistance
State Dept. of Public Welfare
7th and Forester Streets
Harrisburg, Pennsylvania 17120
717 787-1174

Puerto Rico (region II):
Single State Agency:
Department of Health
P.O. Box 9342
Santurce, Puerto Rico 00908
809 751-8259

Medical Assistance Unit:
Health Economy Office
Dept. of Health
P.O. Box 10037
Caparra Heights Station
Rio Piedras, Puerto Rico 00922
809 765-9941

Rhode Island (region I):
Single State Agency:
Dept. of Social and
Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-2121

Medical Assistance Unit:
Division of Medicaid Services
Dept. of Social and Rehabilitative
Services
Aime J. Forand Building
600 New London Ave.
Cranston, Rhode Island 02920
401 464-2174

South Carolina (region IV):
Single State Agency:
State Dept. of Social Services
P.O. Box 1520
Columbus, South Carolina 29202
803 758-3244

Medical Assistance Unit:
Health Care Financing
State Dept. of Social Services
P.O. Box 1520
Columbus, South Carolina 29202
803 758-8182

South Dakota (region VIII):
Single State Agency:
Dept. of Social Services
Kneip Building
Pierre, South Dakota 57501
605 773-3165

Medical Assistance Unit:
Office of Medical Services
Dept. of Social Services
Kneip Building
Pierre, South Dakota 57501
605 773-3495
State Office Building
Pierre, South Dakota 57501
605 224-3495

Tennessee (region IV):
Single State Agency:
Dept. of Public Health
344 Cordell Hull Buliding
Nashville, Tennessee 37219
615 741-3111

Medical Assistance Unit:
Bureau of Medicaid Administration
and Coordination
Department of Public Health
283 Plus Park Boulevard
Nashville, Tennessee 37219
615 741-6661

Texas (region VI):
Single State Agency:
Dept. of Human Resources
P.O. Box 2960
Austin, Texas 78769
512 441-3355

Medical Assistance Unit:
Deputy Commissioner for Medical
Specialties
John H. Reagan Building
Austin, Texas 78701
512 475-3542

Utah (region VIII):
Single State Agency:
Utah State Dept. of Health
150 West North Temple, Rm. 270
Salt Lake City, Utah 84110
801 533-6111

Medical Assistance Unit:
Division of Health Care Financing
and Standards
Utah State Dept. of Health
P.O. Box 2500
Salt Lake City, Utah 84110
801 533-5038

Vermont (region I):
Single State Agency:
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241-2220

Medical Assistance Unit:
Medicaid Division
Dept. of Social Welfare
State Office Building
Montpelier, Vermont 05602
802 241-2800

Virgin Island (region II):
Single State Agency:
Dept. of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-0117

Medical Assistance Unit:
Bureau of Health Insurance and
Medical Assistance
Dept. of Health
Franklin Building
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-4624

Virginia (region III):
Single State Agency:
State Dept. of Health
109 Governor Street
Richmond, Virginia 23219
804 786-3561

Medical Assistance Unit:
Medical Assistance Program
State Dept. of Health
109 Governor Street
Richmond, Virginia 23219
804 786-7933

Washington (region X):
Single State Agency:
Division of Medical Assistance
Dept. of Social and Health
Services
Mail Stop LK-11
Olympia, Washington 98504
206 753-1777

Medical Assistance Unit:
Division of Medical Assistance
Dept. of Social and Health
Services
Mail Stop LK-11
Olympia, Washington 98504
206 753-1777

West Virginia (region III):
Single State Agency:
Office of Assistant
Commissioner of Medical
Services
1900 Washington Street, East
Charleston, West Virginia 25305
304 348-2400

Medical Assistance Unit:
Division of Medical Care
Dept. of Welfare
1900 Washington Street, East
Charleston, West Virginia 25305
304 348-8900

Wisconsin (region V):
Single State Agency:
Dept. of Health and Social
Services
One West Wilson Street
Room 663
Madison, Wisconsin 53702
608 266-3681

Medical Assistance Unit:
Bureau of Health Financing
Division of Health
Dept. of Health and Social
Services
One West Wilson Street
Room 325
Madison, Wisconsin 53702
608 266-2522

Wyoming (region VIII):
Single State Agency:
Dept. of Health and Social
Services
317 Hathaway Building
Cheyenne, Wyoming 82002
307 777-7656

Medical Assistance Unit:
Medical Assistance Services
Division of Health and Social
Services
Department of Health and Social
Services
417 Hathaway Building
Cheyenne, Wyoming 82002
307 777-7541

Appendix 3

Where to Call for Information

A. Medicare

Assignment of Medicare Claims	(301) 594-9437	Peer Review Organizations	
Bureau of Eligibility Reimbursement and Coverage		Office of Professional Standards Review Organization	
		Health Standards Quality Bureau	(301) 594-1432
Beneficiary Assistance on Claims and Entitlement		Physician Provider Data	
Office of Methods and Systems		Analytical Studies Branch	
Bureau of Program Operations	(301)594-9545	Office of Research and Demonstrations, OR	(301) 597-1460
Beneficiary Information		Prevailing Charges Directory	
Office of Beneficiary Services (Woodlawn)	(301) 594-8131	Office of Program Administration	
Office of Beneficiary Services (D.C.)	(202) 245-7684	Bureau of Program Operations	(301) 594-9470
Benefits Appeal Procedures		Problems: Beneficiaries	
Office of Standards and Performance Evaluation		Office of Beneficiary Services	(301) 594-8131
Bureau of Program Operations	(301) 594-8431	Problems: General	
Benefits Information		Office of The Administrator	(202) 245-8502
Bureau of Eligibility, Reimbursement and Coverage	(301) 594-9324	Office of Public Affairs	(202) 472-7728
Conditions of Provider Participation		Procurements—Medicare	
Office of Standards and Certification		Division of Procurement	
Health Standards Quality Bureau	(301) 597-2750	Office of Program Administration	
Contracts		Bureau of Program Operations	(301) 594-8003
Division of Agreements		Professional Standards Review Organization (PSRO)	
Office of Program Administration		Office of Professional Standards Review Organization	
Bureau of Program Operations	(301) 594-9700	Health Standards Quality Bureau	(301) 594-9207
Cost Estimates		Public Information	
Division of Medicare Cost Estimates		Office of Public Affairs (D.C.)	(202) 245-0923
Bureau of Data Management and Strategy	(301) 594-2826	Office of Public Affairs (Woodlawn)	(301) 594-9560
Deductibles: Explanation of Beneficiary Liability		Publications: Office of Research and Demonstrations	
Bureau of Program Policy	(301) 594-9324	ORD Publications Office	(301) 597-2422
Directory of Medical Facilities		Publications: HCFA	
Division of Field Operations		Office of Public Affairs	(202) 245-0923
Health Standards Quality Bureau	(301) 594-7940	Quality Control	
Enrollment Policy		Office of Quality Control Programs	
Bureau of Eligibility, Reimbursement and Coverage	(301) 594-9324	Bureau of Quality Control	(301) 597-1348
Entitlement		Quality of Care Issues	
Bureau of Eligibility, Reimbursement and Coverage	(301) 594-9324	Office of Professional Standards Review Organization	
Fraud, Abuse and Waste Allegation or Complaints		Health Standards Quality Bureau	(301) 594-9207
Bureau of Quality Control		Reasonable Charges	
Field Operations Branch		Bureau of Eligibility, Reimbursement and Coverage	(301) 594-9207
Division of Validation Planning and Support, BQC	(301) 594-2078		

Reimbursement Methods		Statistics: Beneficiaries	
Division of Reimbursement Studies		Division of Beneficiary Studies	
Office of Research and Demonstrations	(202) 245-6306	Office of Research and Demonstrations	(301) 597-1432
Reimbursement Policy		Statistics: General	
Bureau of Reimbursement and Coverage	(301) 594-9324	Division of Information Analysis	
		Bureau of Data Management and Strategy	(301) 594-6705
Regional Offices, HCFA		Statistics: Institutional Care	
Boston	(617) 223-6871	Institutional Studies Branch	
New York	(212) 264-4488	Office of Research and Demonstrations	(301) 597-5710
Philadelphia	(215) 596-1351		
Atlanta	(404) 221-2329		
Chicago	(312) 353-8057		
Dallas	(214) 767-6427	Statistics: Medicare Program	
Kansas City	(816) 374-5233	Program Statistics Branch	
Denver	(303) 837-2111	Office of Research and Demonstrations	(301) 597-1423
San Francisco	(415) 556-0254		
Seattle	(206) 442-0425	Statistics: Non-institutional Studies	
Research Results		Non-Institutional Studies Branch	
Office of Research and Demonstrations	(301) 597-3195	Office of Research and Demonstrations	(301) 594-8752
Rural Health Clinic Services		Statistics: Professional Standards Review Organization	
Division of Operations		Division of Planning and Analysis	
Office of Program Administration		Health Standards Quality Bureau	(301) 594-9207
Bureau of Program Operations	(301) 594-9101		
Service Coverage		Fraud and Abuse	
Bureau of Reimbursement and Coverage	(301) 594-9324	Field Operations Branch	
		Office of Program Validation	
State and Contractor Standards		Bureau of Quality Control	
Office of Standards and Performance Evaluations		Health Care Financing Administration	(301) 594-2078
Bureau of Program Operations	(301) 594-8431		
State Buy-ins			
Office of Methods and Systems			
Bureau of Program Operations	(301) 594-9545		

B. Medicaid

Abortion Data

Office of Standards and Performance (301) 594-8785
Evaluation
Bureau of Program Operations

Administration and Training Cost Data

Office of Financial Management (301) 594-6703
Services
Office of Management and Budget

AFDC Eligibility, Need and Payment Standards

Office of Research and Statistics (202) 472-4333
Office of Policy
Social Security Administration

Eligibility

Division of Medicaid Eligibility Policy (301) 594-9050
Office of Eligibility Policy
Bureau of Eligibility, Reimbursement and Coverage

EPSDT Data

Office of Standards and Performance (301) 594-8788
Evaluation
Bureau of Program Operations

Expenditures

Total Program Expenditure (301) 597-1702
Division of Finance
Bureau of Program Operations

Medicaid Vendor Payments

Division of Medicaid Cost Estimates (301) 594-1417
Bureau of Data Management and Strategy

Medicaid Institutional Providers

Office of Statistics and Data Management (301) 594-0942
Office of Research and Demonstrations

Medicaid Management Information Systems

Office of Methods and Systems (301) 594-8441
Bureau of Program Operations

Medicaid Statistics

Division of Medicaid Cost Estimates (301) 597-1411
Bureau of Data Management and Strategy

Medically Needy Income Levels

State Plans Branch (301) 594-7084
Division of Agreements
Bureau of Program Operations

Procurements—Medicaid

Division of Procurement (301) 594-8003
Office of Program Administration
Bureau of Program Operations

Recipients

Division of Medicaid Cost Estimates (301) 597-1411
Bureau of Data Management and Strategy

State and Local Administration and Training

Office of Financial Management (301) 594-8746
Services
Office of Management and Budget (301) 594-6703

State Buy-in Data

Medical Program Data Branch (301) 594-5883
Office of Research and Demonstrations

State Certification Cost Data

Financial Management Branch (301) 597-7032
Health Standards Quality Control

State Data

Division of Medicaid Cost Estimates (301) 597-1417
Bureau of Data Management and Strategy

State Plans

State Plans Branch (301) 594-7084
Division of Agreements
Bureau of Program Operations

Supplemental Security Income

Office of Research and Statistics (202) 673-5747
Office of Policy
Social Security Administration

Third-Party Liability

Division of Operations (301) 594-9101
Office of Program Administration (301) 594-6703
Bureau of Program Operations

Utilization

Division of Medicaid Cost Estimates (301) 597-1417
Bureau of Data Management and Strategy

Health Care Financing Administration Regional Offices

Regional Administrators

Region I	John D. Kennedy	John F. Kennedy Federal Building Government Center Boston, Massachusetts 02203 (617) 223-6871
Region II	William Toby	Jacob K. Javits Federal Building 26 Federal Plaza New York, New York 10278 (212) 264-4488
Region III	Everett Bryant	3535 Market Street P.O. Box 13716 Philadelphia, Pennsylvania 19101 (215) 596-1351
Region IV	George R. Holland	101 Marietta Tower Atlanta, Georgia 30323 (404) 221-2329
Region V	Barbara J. Gagel	175 W. Jackson Boulevard Chicago, Illinois 60604 (312) 353-8057
Region VI	Jerry Sconce	1200 Main Tower Dallas, Texas 75202 (214) 767-6427
Region VII	Gene Hyde	601 East 12th Street Kansas City, Missouri 64106 (816) 374-5233
Region VIII	Francis Ishida	1961 Federal Building Stout Street Denver, Colorado 80294 (303) 837-2111
Region IX	Robert D. O'Connor	100 Van Ness Avenue 14th Floor San Francisco, California 94102 (415) 556-0254
Region X	Joseph E. Anderson	The Third and Broad Building 2901 3rd Avenue Seattle, Washington 98121 (206) 442-0425

Appendix 4

Glossary of Medicare and Medicaid Terms

Aged—For purposes of enrollment under Medicare, persons attaining age 65 years or over are considered to be aged. The term is not relevant for the aged 65 and over basis of eligibility group in the Medicaid program.

Assignment—Under supplementary medical insurance, if the enrollee and the service provider both agree, the enrollee may assign his rights to benefits to the provider. When this assignment method is used, assignment means the provider agrees that his total charge for the covered service will be the reasonable charge approved by the carrier. The provider submits a claim to the carrier, and is reimbursed for the reasonable charge, minus the 20 percent coinsurance and any unmet deductible. The provider may then charge the enrollee only for the coinsurance and the unmet deductible.

Automatic Enrollment—Retirement and survivors insurance beneficiaries are automatically sent Medicare cards 3 months before they attain age 65; those entitled to disability benefits are automatically sent Medicare cards 3 months before the completion of 24 consecutive months of entitlement. These Medicare cards show entitlement to both hospital insurance (HI) and supplementary medical insurance (SMI); an enrollee wishing to decline SMI coverage must do so in writing no later than the month prior to the effective date of coverage.

Benefit Period—A benefit period is the period used to limit Medicare benefits in the hospital insurance program. A benefit period begins the first day an enrollee is furnished inpatient hospital or extended care services by a qualified provider, and ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Carrier—A carrier is an organization that has contracted with the Department of Health and Human Services (DHHS) to process claims and perform other services under Medicare's SMI program.

Categorically Needy—Under Medicaid, categorically-needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet financial eligibility requirements for Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or an optional State supplement.

Coinsurance—Coinsurance is that portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not cover. Under hospital insurance (HI), there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsur-

ance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility (SNF) care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under supplementary medical insurance (SMI), after the annual deductible has been met, Medicare will pay 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the enrollee. However, there is no coinsurance for home health services under SMI.

Copayment—Copayments are a type of cost-sharing under Medicaid whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer pays the rest of the cost.

Covered Services—Covered services are the services and supplies for which Medicare will reimburse. Examples of covered services are given in this Glossary under specific headings, such as Emergency Services and Skilled Nursing Facility services. Covered services under the Medicaid program consist of a combination of mandatory and optional services within each State.

Customary Charge—Customary charges are the amounts physicians or suppliers usually bill patients for furnishing particular services or supplies.

Deductible—Deductibles are the amounts paid by enrollees for covered services before Medicare makes reimbursements. The hospital insurance (HI) deductible applies to each new benefit period, is determined each year by a formula specified by law, and approximates the current cost of a one-day inpatient hospital stay. The supplementary medical insurance (SMI) deductible is, by law, the first \$75 of covered charges per calendar year, effective January 1, 1982.

Disabled—For purposes of enrollment under Medicare, individuals under 65 years of age who have been entitled for not less than 24 months to disability benefits under the Social Security Act or the railroad retirement system are entitled to Medicare.

Discharge—A discharge is a formal release from a hospital or a skilled nursing facility (SNF). Discharges include persons who died during their stay, or were transferred to another facility.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)—The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

End-Stage Renal Disease (ESRD)—To enroll under Medicare, individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have end-stage renal disease. To qualify for Medicare coverage, the individual must be fully or currently insured under social security or the railroad retirement system, or be the dependent of an insured person. Eligibility for Medicare coverage begins with the 3rd month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility; or if a person receives a kidney transplant without starting or receiving dialysis.

Enrollment Period—Effective October 1, 1981, the 1981 Act repealed SMI continuous open enrollment and reinstated the general enrollment period of January 1 through March 31 of each year. Coverage takes effect July 1.

Expenditure—Under Medicaid, expenditure refers to an amount paid out by a State agency for the covered medical expenses of eligible participants.

Family Planning Services—Family planning services are any medically approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling which are furnished or prescribed by or under the supervision of a physician for individuals of child-bearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.

Federal Hospital Insurance Trust Fund—The Federal hospital insurance (HI) trust fund is a trust fund of the Treasury of the United States in which are deposited monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by social security. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program.

Federal Supplementary Medical Insurance Trust Fund—The Federal supplementary medical insurance (SMI) trust fund is a trust fund of the Treasury of the United States consisting of amounts deposited in or appropriated to the fund as provided by Title XVIII of the Social Security Act, including premiums paid by enrollees under SMI and contributions by the Federal Government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Fiscal Agent—A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. Under Medicare, fiscal agents are called intermediaries (HI), and carriers (SMI).

Fiscal Year—Data for fiscal years 1972 through 1976 were from July 1 through June 30. Beginning with October 1, 1977, fiscal years are from October 1, through September 30.

General Hospital—A general hospital is a hospital maintained primarily for inpatient care of acute illness or injury, and for obstetrics.

Group Practice Prepayment Plan—In general, members of group practice prepayment plans (GPPP's) pay regular premiums to the plan. In return, the members receive the health services the plan provides without additional charge. Many prepayment plans have made arrangements with Medicare to receive direct payments for services they furnish which are covered by SMI.

Health Insuring Organization—A health insuring organization pays for medical services provided to recipients who pay a premium or subscription charge to the entity, which assumes an underwriting risk with regard to expenses for the services provided.

Health Maintenance Organization—Some group practice prepayment plans also provide many inpatient services, and therefore have contracts with Medicare as Health Maintenance Organizations (HMO's) which allow them to receive direct payment for services covered by hospital insurance and supplementary medical insurance.

Home Health Agency—A home health agency (HHA) is a public or private organization providing skilled nursing services and other therapeutic services in the patient's home, and which meets certain conditions to ensure the health and safety of the individuals furnished services.

Home Health Services—Home health services are services and items furnished in patient's homes under the care of physicians by home health agencies (HHA's) or by others under arrangements made by such agency. The services are furnished under a plan established and periodically reviewed by a physician. The services include: part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services, medical supplies and appliances (other than drugs and biologicals); home health aide services; and services of interns and residents.

Hospital Insurance—Hospital insurance (HI) (also known as Medicare: Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 and over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for not less than 24 months to disability benefits under the social security or railroad retirement systems, and for certain other individuals who are medically determined to have end-stage renal disease and are covered by the social security or railroad retirement systems.

Independent Laboratory—An independent laboratory is a laboratory certified to perform diagnostic tests independent of a physician's office or hospital and receive reimbursements from Medicare.

Inpatient Hospital Services—Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Intermediary—An intermediary is an organization selected by providers of health care which has an agreement with DHHS under Medicare's hospital insurance program to process claims and perform other functions.

Intermediate Care Facility—An intermediate care facility (ICF) is an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (Medicaid) of the Social Security Act.

Laboratory and Radiological Services—Laboratory and radiological services are professional and technical laboratory and radiological services ordered by a licensed practitioner and provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified laboratory.

Lifetime Reserve—A Medicare hospital insurance (HI) enrollee has a non-renewable lifetime reserve of 60 days of inpatient hospital care to draw upon if the 90 covered days per benefit period are exhausted.

Long-Stay Hospital—A long-stay hospital is one in which the average patient stay is 30 days or more.

Medically Needy—Under Medicaid, medically-needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, and whose income resources are above the limits for eligibility as categorically needy (AFDC or SSI) but are within limits set under the Medicaid State plan.

Noninstitutionalized, Civilian Population—All persons residing in the United States during 1980 who were not members of the military (uniformed services) or not residing in institutions (correctional facilities, nursing homes, etc.).

Other Practitioners' Services—Other practitioners' services are health care services of licensed practitioners other than physicians and dentists.

Outpatient Hospital Services—Outpatient hospital services are services furnished to outpatients by a participating hospital, for diagnosis or treatment of an illness or injury.

Outpatient Services—Outpatient services are medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Persons Served—Under Medicare, a person served is a Medicare enrollee who uses a covered medical service, incurs expenses greater than the deductible amount, and for whom Medicare paid benefits.

Physicians' Services—Under Medicare and Medicaid, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Portable X-Ray—A portable X-ray is a radiograph taken with portable equipment, usually in the patient's place of residence, under the general supervision of a physician.

Premium—A premium is a monthly fee paid by Medicare enrollees. Hospital insurance (HI) enrollees who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. Supplementary medical insurance (SMI) enrollees pay a monthly premium which is updated every July to reflect changes in program costs.

Premium Hospital Insurance—Persons 65 years of age and over who are not automatically eligible for hospital insurance (HI) may obtain coverage by paying a monthly premium.

Prescribed Drugs—Prescribed drugs are drugs dispensed by a licensed pharmacist on the prescription of a practitioner licensed by law to administer such drugs, and drugs dispensed by a licensed practitioner to his own patients. This item does not include a practitioner's drug charges that are not separable from his other charges, or drugs covered by a hospital bill.

Prevailing Charge—The prevailing charge is the charge at the 75th percentile in an array of the weighted customary charges made for similar services in the same locality. This is the upper limit of charges deemed "reasonable" for Medicare reimbursement for similar services.

Professional Standards Review Organization (PSRO)—A PSRO is a physician or other professional medical organization (consisting of physicians and other health professionals with independent admitting hospital privileges) that enters into an agreement with DHHS to assume the responsibility for the review of the quality and appropriateness of services covered by, Medicare, Medicaid, and the Maternal and Child Health program. PSRO's determine whether services are medically necessary, provided in accordance with professional standards, and, in the case of institutional services, rendered in the appropriate setting.

Psychiatric Hospital—A psychiatric hospital is an institution primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mental illness.

Railroad Retirement System—The railroad retirement system was mandated by the Railroad Retirement Act of 1937 as a retirement system for railroad employees.

Reasonable Charge—In processing claims for SMI benefits, carriers use Health Care financing Administration (HCFA) guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier; the charge the physician or supplier customarily bills his patients for the same service; and the prevailing charge which most physicians or suppliers in that locality bill for the same service. Increases in the physicians' prevailing charge levels are recognized only to the extent justified by an index reflecting changes in the costs of practice and in general earnings.

Reasonable Cost—In processing claims for HI benefits, intermediaries use HCFA guidelines to determine the reasonable cost incurred by the individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the HI program.

Recipient—A recipient of Medicaid is an individual who has been determined to be eligible for Medicaid and who has used medical services covered by Medicaid.

Reimbursement—Under Medicare, the reimbursement amount refers to the dollar amount of medical expenses payable by the Medicare program. (For Medicaid, see Expenditures).

Rural Health Clinic—A rural health clinic is an outpatient facility which is primarily engaged in furnishing physicians' and other medical and health services, and which meets certain other requirements designed to ensure the health and safety of the individuals served by the clinic. The clinic must be located in a medically underserved area that is not an urbanized area as defined by the Bureau of the Census and that is designated by the Secretary of DHHS either as an area with a shortage of personal health services, or as a health manpower shortage area, and has filed an agreement with the Secretary not to charge an individual or other person for items or services for which such individual is entitled to have payment made by Medicare, except for the amount of any deductible or coinsurance amount applicable.

Short-Stay Hospital—A short-stay hospital is one in which the average length of stay is less than 30 days. General and special hospitals are included in this category.

Skilled Nursing Facility—A skilled nursing facility (SNF) is an institution which has a transfer agreement with one or more participating hospitals, and which is primarily engaged in providing to inpatients skilled nursing care and rehabilitative services, and meets specific regulatory certification requirements.

Skilled Nursing Facility Services—SNF services are all services furnished to inpatients of, and billed by, a certified SNF that meets standards required by the Secretary of DHHS.

Spend-Down—Under the Medicaid program, spend-down refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.

State Buy-In—State buy-in is the term given to the process by which a State may provide SMI coverage for its needy eligible persons through an agreement with the Federal Government under which the State pays the premiums for them.

State Plan—The Medicaid State plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Supplemental Security Income (SSI)—SSI is a program of income support for low-income aged, blind, and disabled persons, established by Title XVI of the Social Security Act.

Supplementary Medical Insurance (SMI)—SMI (also known as Medicare: Part B) is a voluntary insurance program which provides insurance benefits for physician and other medical services in accordance with the provisions of Title XVIII of the Social Security Act, for aged and disabled individuals who elect to enroll under such program. The program is financed by premium payments by enrollees, and contributions from funds appropriated by the Federal government.

Third-Party Liability—Under Medicaid, third-party liability exists if there is any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Vendor—A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical services.

Appendix 5

Medicare and Medicaid Abbreviations

AABD	Aid to the Aged, Blind, and Disabled	ICF	Intermediate Care Facility
AB	Aid to the Blind	ICU	Intensive Care Unit
ADP	Automatic Data Processing	JCAH	Joint Commission on the Accreditation of Hospitals
AFDC	Aid to Families with Dependent Children	MAC	Maximum Allowable Cost
APTD	Aid to the Permanently and Totally Disabled	MAO	Medical Assistance Only
CCU	Coronary Care Unit	MMIS	Medicaid Management Information System
CFR	Code of Federal Regulation	MQC	Medicaid Quality Control
CP	Claims Processing	OAA	Old Age Assistance
DHHS	Department of Health and Human Services	OIG	Office of the Inspector General
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment	PSRO	Professional Standards Review Organization
ESRD	End-Stage Renal Disease	RRF	Railroad Retirement Fund
FFP	Federal Financial Participation	SMI	Supplementary Medical Insurance
GPPP	Group Practice Prepayment Plan	SNF	Skilled Nursing Facility
HCFA	Health Care Financing Administration	SSA	Social Security Administration
HHA	Home Health Agency	SSI	Supplemental Security Income
HI	Hospital Insurance	TPL	Third-Party Liability
HMO	Health Maintenance Organization		

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